☐ Insurance Cards Copied
Date: _____

Account #: _____
Co-Payment: $_____

Patient Information Registration

Please PRINT and complete all sections below

WHO IS YOUR PHYSICIAN IN THE PRACTICE? _____

PATIENT'S PERSONAL INFORMATION Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Name: _____
Last First Middle Initial
Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____
Please specify which phone number is best to reach you at: _____ Email Address: _____

Date of Birth: _____ Driver's License State & Number: _____
month / day / year state number
Soc. Sec. #: _____ Employer Name: _____

Work Address: _____ Occupation: _____

How do you wish to be addressed? _____ Spouse's Name: _____
Last First Middle Initial
Spouse's Employer: _____ Spouse's Work Phone: (_____) _____
Spouse's Soc. Sec. #: _____ Spouse's Date of Birth: _____
month / day / year

PATIENT / RESPONSIBLE PARTY INFORMATION
Responsible Party: _____ Date of Birth: _____
Last First Middle Initial month / day / year
Relationship to Patient: ☐ Self ☐ Spouse ☐ Other Social Security #: _____
Responsible Party's Home Phone: (_____) _____ Work Phone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____

PATIENT'S INSURANCE INFORMATION **Please present insurance card(s) to the receptionist**
PRIMARY Insurance Company's Name: _____
Insurance address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Date of Birth: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Other
Insurance ID #: _____ Group #: _____ Effective Date: _____

SECONDARY Insurance Company's Name: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Date of Birth: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Other
Insurance ID #: _____ Group #: _____ Effective Date: _____
Check if appropriate: ☐ Medigap Policy ☐ Retiree Coverage

PATIENT'S REFERRAL INFORMATION **(Please include address and phone numbers)**
Primary Care Physician: _____ Referred By: _____
Attorney: _____ Other physician(s) who care for you: _____
_____

EMERGENCY CONTACT
Name of person **NOT** living with you: _____ Relationship: _____
Address: _____ Phone #: (_____) _____ Work #: (_____) _____
City Zip

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to **ADVANCED PAIN MANAGEMENT**, for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize APMR (health care providers) to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Signature: _____