REGISTRATION FORM

Date: _____/_____/2012

Home Telephone: _____/_____/_____ **Mobile Telephone: _____/_____/_____**

E-Mail Address:_____ SS#_____/_____/_____

Patient's Name: _____ _____
Last First Initial

Street Address: _____ APT#_____

City_____ State: ____ Zip Code: _____/_____ Birth date: _____/_____/_____ Age: _____

How did you hear about us? ☐ Newspaper ☐ Seminar ☐ TV ☐ Friend_____

Family Doctor's Name:_____ ☐ Other_____

Doctor's Address_____Doctor's Phone Number _____/_____/_____

Employer's Name:_____ Occupation:_____

Street Address:_____ Telephone: _____/_____/_____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ _____
Last First Initial

Relationship to Insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other:_____**

Birth date: _____/_____/_____ SS#: _____/_____/_____ Occupation:___ _____

Employer's Name: _____ Local #: _____

Street Address: _____ Telephone: _____/_____/_____

City: _____ State: _____ Zip Code: _____

Please provide 2 alternate names and telephone numbers in case of an emergency:

Name:_____Relation:_____Telephone: _____

Name: _____ Relation: _____ Telephone: _____

I, the undersigned, have Insurance Coverage with _____
NAME OF INSURANCE COMPANY

And assign directly to Midwest Anesthesia and Pain Specialists, all medical benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Patients/ Guardian Signature_____Date:_____/_____/2012

Home Health Care: I do <u>not</u> currently receive any home health care services

Signature_____ Date____/_____/2012