CENTERS FOR PAIN CONTROL

REGISTRATION FORM

Date: _____/______/20__

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____________________ ☐ Other____________________

Family Doctor's Name:____

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:_____/_____/20__

Home Health Care: I do not currently receive any home health care services

Signature____ Date____/_____/20__