

# Interventional Pain Management Physicians, P.A.

## PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**  
All information will be strictly confidential. **TODAY'S DATE:** \_\_\_\_\_

Patient's Name	Sex M F	Birth Date ____/____/____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]			
Referred by:		Age _____				
Residence address	City	State	Zip	Home Phone:	Patient's Social Security #	
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/____	Responsible Party's Social Security #			
Name of Spouse/Parent	Birth date	Social security #	Business phone			
Reason for Visit:						
Person to contact in case of emergency:			Relationship to patient	Phone		
Workers' Compensation? Yes [ ] No [ ]	Motor Vehicle? Yes [ ] No [ ]	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #	
<b>If Yes-put W/C or MVA carrier above</b>						
Primary insurance	Medicare Yes [ ] No [ ]	Medicaid Yes [ ] No [ ]	Address		Is insurance through your employer?	
Subscriber Name	Subscriber SS#	Subscriber birth date	Policy #	Group #		
Secondary insurance name						Address
Subscriber Name	Subscriber SS#	Subscriber birth date	Policy #	Group #		

### Assignment of Benefits/Medicare Lifetime Signature

I hereby authorize payment directly to the physician of the surgical or medical benefits, if any, for his services, I realize I am responsible for noncovered services, co-payments and deductibles, I also understand that this assignment does not relieve my liability on these services. I request payment of authorized Medicare benefits be made on my behalf to Interventional Pain Management Physicians, P.A. for any service furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Release of Information

I hereby authorize the physician to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company(ies).

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Consent For Treatment

\_\_\_\_\_, the patient and/or legal guardian of said patient do hereby give my consent for medical examination and treatment under the care of the practice and deemed necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Acknowledgement of Receipt of Notice of Privacy Practice

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practice.

Signature \_\_\_\_\_ Date \_\_\_\_\_