Integrative PAIN CLINIC

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www.integrativepainclinic.com

Get Back To Living Life

Date: _____

Patient Registration Form

Referring MD: _____ Ph. Number: _____ Fax Number:_____

PCP: _____ Ph. Number: _____ Fax Number: _____

Patient Information

First Name: _____ MI: _____ Last Name: _____ M ☐ F ☐

DOB: _____ SSN: _____ Marital Status: S ☐ M ☐ D ☐ W ☐ LS ☐

Home Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone No. : _____ Cell Phone No. : _____ Email: _____

Emergency Contact

First Name: _____ Last Name: _____ Relationship: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone No. 1: _____ Phone No. 2: _____

Insurance Information

☐ PPO ☐ HMO (Referral Needed) ☐ Co-pay for Specialist: _____

Primary Insurance Name: _____

Name of Policy Holder: _____ DOB (If not themselves.): _____

Relationship to Patient: _____

Patient's Policy ID No. : _____ Policy Start Date: _____

Secondary Insurance Information (if applicable)

Secondary Insurance Name: _____

Name of Policy Holder: _____ DOB (If not themselves.): _____

Relationship to Patient: _____

Patient's Policy ID No. : _____ Policy Start Date: _____

Physician Use Only

☐ Medical Records Received

☐ Insurance Verification

Type of Pain: _____

Appointment Date and Time: _____

Pharmacy Name: _____

Pharmacy Number: _____

☐ Pharmacy Records Received