PATIENT REGISTRATION FORM

Please Print Clearly

Patient's Full Name:____________________ Age: _____ DOB:_______ Sex: ___

Address: ____________________ City: __________ Zip: ______

Home Phone:____________________ Married Single Divorced Separated Widowed

Social Security # ____________________ Driver's License # ____________

Patient's Employer: ____________________ Phone:____________________

Address: ____________________ City: __________ Zip: ______

Occupation:____

Spouse's Name: ____________________ Social Security # ____________

Address: ____________________ City: __________ Zip: ______

Employer:____________________ Driver's License # ____________

Family Physician: ____________________ Referred by:________________

In case of emergency, contact (other than spouse) ____________________________

Address: ____________________ City: __________ Zip: ______

Relationship: ____________________ Phone:____________________

INSURANCE INFORMATION:

Primary Insurance: ________________ Secondary Insurance: ________________

ID #____________________ ID # ____________________

Group # ____________________ Group # ____________________

Subscriber: ____________________ Subscriber:____________________

Effective Date:____________________ Effective Date: ____________________

We ask all patients to show their insurance cards and driver's license so that we may make copies of them. Should your name, insurance information, address or phone number change, please notify us.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance carriers and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION:

I, ____________________, hereby authorize Western Reserve Spine & Pain to furnish information concerning my present illness. I direct the insurer to pay, without equivocation directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostat copy of this authorization will be as valid as the original.

Signature of Patient, Parent or Guardian:____________________ Date:____________