PRO SPINE & PAIN

Phone: 262-297-7246
Fax: 888-714-0578

PATIENT REGISTRATION FORM

PATIENT - THIS SECTION REFERS TO PATIENT ONLY

Please print and complete all information requested on this form.

Name _____ Age _____ Date of Birth _____

SS No. _____ Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Maiden Name _____ Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

RESPONSIBLE PARTY-THIS SECTION REFERS TO THE PERSON RESPONSIBLE FOR PAYMENT

Check which one applies ☐ Self ☐ Patient is a minor. *See insurance information below.*

PERSON TO CONTRACT IN CASE OF EMERGENCY

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE INFORMATION

Please check which one applies to you and complete information below. ☐ Insurance ☐ Workman's Compensation ☐ Self Pay

Insurance Company' s Name and Address _____

Phone Number _____ Insured's Name (who holds insurance) _____ Insured's Date of Birth _____

Relationship to Patient _____

HIC/Policy Number or Social Security Number _____ Group Number _____

WORK COMP and MVA —REQUIRED INFORMATION

Case worker' s name _____ Phone _____ Claim# _____

Date of Injury (REQUIRED) _____

SECONDARY INSURANCE INFORMATION

Insurance Company' s Name and Address _____

Phone Number _____ Insured's Name (who holds insurance) _____ Insured's Date of Birth _____

Relationship to Patient _____

HIC/Policy Number or Social Security Number _____ Group Number _____

ASSIGNMENT OF BENEFITS

I hereby assign to Pain Physicians of Wisconsin any insurance or third-party benefits available for healthcare services provided to me. I understand that Pain Physicians of Wisconsin has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Pain Physicians of Wisconsin, I agree to forward the practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

Signature of Patient / Legal Guardian _____ DATE _____