SPECTRUM PAIN CLINICS
~A Division of Encore Health Group~

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 Spectrum Pain Clinics any insurance or third-party benefits available for healthcare services provided to me. I understand that Spectrum Pain Clinics has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Spectrum Pain Clinics, 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 ______