Consultants in Pain Management

Patient Registration

Patient's Name ____Phone# (Home)______________(Cell)____________

Address____Social Security #______/_____/_________

City ______________________________St ______Zip ______Age______ Date of Birth____/___/___Race__________

Female __Male ___Marital Status : S ___ M ___ W ___ D __Email address__________________________________

Ethnicity: African American, American Indian, Asian, Black American, Chinese, European American, German, Hispanic,

Latino, Russian, White American, Other _______________________Primary Language___________________________

Education: Less than High School completion, Completed High School or equal, Some college / 2 year degree,
4 or more years completed

Name of Employer_______________________________________Address_____________________________________

City _____________________________St _______Zip ______Phone (Work)_________________________________

Referring Physician_________________________ Primary Care Physician_____________________________________

Spouse's Name________________________________Employer__________________________Phone_______________

Emergency Contact not living with you____Phone_______________
Relationship to Contact ____

If Minor Child :

Father's Name________________________________Employer__________________________Phone_________________

Mother's Name______________________________Employer__________________________Phone_________________

INSURANCE INFORMATION

Primary Insurance

Company Name_____________________________

Policy in name of____________________________

Date of Birth _______Social Sec.#____/____/____

Group Number______________________________

Policy Number______________________________

Secondary Insurance

Company Name___________________________________

Policy in name of_________________________________

Date of Birth _________Social Sec. #_____/____/_______

Group Number____________________________________

Policy Number____________________________________

Is this visit work related? N________ Y________

Claim number_______________________________

Adjuster / Phone______________________________

Workers Comp Insurance Information

Company Name____

Address____