ADVANCED PAIN TREATMENT

Phone: 608-580-8252
Fax: 866-950-0314

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