

REGISTRATION FORM

PATIENT NAME : (Last) _____ (First) _____ (MI) _____
Social Security #: _____ Sex: M F DOB: _____ Marital Status: S M D W
ADDRESS: (Street) _____
(City) _____ (State) _____ (Zip) _____ Home Phone #: _____
Employer Name: _____ Occupation: _____ Work Phone #: _____
Employer Address: _____ (City) _____ (State) _____ (Zip) _____
Emergency Contact Name: _____ Phone #: _____

REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION

If you would like a report sent to your physician please check here

Referring Physician: _____ Phone #: _____
Street Address: _____ Fax #: _____
(City): _____ (State) _____ (Zip) _____
Primary Care Physician: _____ Phone #: _____
Street Address: _____ Fax #: _____
(City) _____ (State) _____ (Zip) _____

How Did You Hear About Our Practice? (Check all that apply)

- Physician (Name: _____)
 Hospital (Name : _____) Newspaper Radio Internet
 Friend/Relative (Name : _____) Television Yellow Pages Insurance Directory

INSURANCE INFORMATION

WORKER'S COMPENSATION/AUTO (PLEASE CIRCLE IF APPLICABLE AND COMPLETE THIS SECTION)

Ins. Company Name: _____ Claim #: _____
Billing Address: _____ (City) _____ (State) _____ (Zip) _____
Date of Accident: _____ State Accident Occurred in: _____
Adjuster's Name: _____ Phone #: _____ Fax #: _____
Area(s) of Injury (list all body parts): _____

PRIMARY INSURANCE

Ins. Company Name: _____ Phone #: _____
Billing Address: _____ (City) _____ (State) _____ (Zip) _____
Policy Holder's Name: _____ Relationship to Patient: _____
Policy ID #: _____ Group #: _____ Policy Holder's D.O.B.: _____

SECONDARY INSURANCE

Ins. Company Name: _____ Phone #: _____
Billing Address: _____ (City) _____ (State) _____ (Zip) _____
Policy Holder's Name: _____ Relationship to Patient: _____
Policy ID #: _____ Group #: _____ Policy Holder's D.O.B.: _____

All co-payments, non-covered services and/or products are to be paid at the time of services.

Commercial/Worker's Compensation/Auto Patients:

- I authorize the release of any medical information necessary to process all claim and I authorize payment of medical benefits to **Gupta Institute for Pain/MPiPM** for services rendered.
- All Auto/Worker's Compensation are also required to give their private health insurance information, including any necessary referrals, in the event a denial is received from your auto or work comp carrier.

Medicare Patients:

- I authorize Medicare to pay approved benefits directly to **Gupta Institute for Pain / Midatlantic Personal Injury Pain Management (MPiPM)**
- I authorize the release of any medical information necessary to determine benefits to the Centers for Medicare and Medicaid.
- If Medicare is my only insurance carrier, I understand that I am fully responsible for 20% co-insurance due after Medicare payment.

HMO Patients

- I understand that that *it is my responsibility to supply a referral/authorization from my PCP* and that any co-payment associated with my HMO is due at the time of service.
- I may be asked to reschedule or pay for my visit *if no referral is supplied.*

Signature: _____ Date: _____