PATIENT 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 :_____)
☐ Friend/Relative (Name :_____)
☐ Newspaper ☐ Radio ☐ Social Media
☐ Television ☐ Yellow Pages ☐ Internet ☐ 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.***

I acknowledge the receipt of NOTICE OF (HIPPA)PRIVACY PRACTICES given to me by Gupta Institute.

Signature: _____ Date: _____