CENTRAL ARKANSAS PAIN CENTER
REGISTRATION FORM

Primary Care or Referring Physician	Address:	Today's Date

PATIENT INFORMATION

Patient's Last Name	First	Middle	□ Mr. □ Miss □ Mrs . □ Ms.	Marital Status (Check One) □ Single □ Married □ Divorced □ Widowed

Is this your legal name?	If not, what is your legal name?	Maiden Name	Birth Date / /	Age	Sex □ Male □ Female

Address City State Zip	Social Security Number	Home Phone

Would you like to receive your statement via E-mail? □ Yes □ No	E-mail Address:

Are you employed? □ Yes □ No	If yes, □ Full-time □ Part-time	Occupation

Employer	Employer's Address	Employer's Phone Number

How did you hear about us? □ Referring Physician □ Phone Book □ Family or friends □ ER □ Other (please specify)

PRIMARY INSURANCE (If any information is the same as above, please put "same" in appropriate section)

Name of Insured	Birth Date	Address (if different)	Home Phone
Social Security Number			

Occupation	Employer	Employer's Address	Work Phone
Insurance Company	Insurance Phone	Insurance ID #	Group #

Relationship to Patient	□ Self	□ Spouse	□ Parent	□ Other (specify)

SECONDARY INSURANCE (If any information is the same as above, please put "same" in appropriate section)

Name of Insured	Birth Date	Address (if different)	Home Phone
Social Security Number			

Occupation	Employer	Employer's Address	Work Phone
Insurance Company	Insurance Phone	Insurance ID #	Group #

Relationship to Patient	□ Self	□ Spouse	□ Parent	□ Other (specify)

ACCIDENT

Accident □ Yes □ No	Type	□ Auto	□ Home	□ Work	□ Other

Date and Circumstances of Injury — Claim Number

Insurance Company - Address - Phone Number — Adjuster Handling Claim

Attorney – Address – Phone Number

IN CASE OF EMERGENCY: _____

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF MEDICAL INFORMATION:
I request that payment of my insurance benefits be made on my behalf to the clinic for any services furnished to me by any doctor in the clinic. I authorize any holder of medical information about me, to release this information, if needed to determine these benefits. **I understand that I am financially responsible for any balance not covered by my insurance carrier.**

Signed: _____ **Date:** _____