Patient Registration

PLEASE PRINT CLEARLY

Date: ____________________

Patient Information

Legal Name ____ Sex ________________
Date of Birth _________________________ Social Security # ______________________
Address ____ Apt # ____________
City ________________________________ State ________________ Zip____________
Home Phone ____________________________ Work Phone ________________________
Employer ____
Employer Address ____
City ________________________________ State ________________ Zip ___________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Name of Referring Doctor: __________________________ Phone ___________________
Name of Primary Doctor: ___________________________ Phone ___________________

Spouse/Guardian Information

Legal Name ________________________________Social Security # _________________
Address ____ Apt # ________________
City _________________________________ State ________________ Zip ___________
Home Phone ______________________________ Work Phone ______________________
Employer ____
Employer Address ____
City ________________________________ State ________________ Zip ___________

Emergency Contact Information

Contact Name ______________________________________ Relationship _____________
Address ____
City ________________________________ State ________________ Zip ____________
Employer ____
Address ____
Home Phone _______________________________ Work Phone ____________________

Primary Insurance

Insurance Company ____
Policy/Group# ___________________________ ID# ______________________________
Name of Insured _____________________________ Effective Date: __________________

Secondary Insurance

Insurance Company ____
Policy/Group# ___________________________ ID# ______________________________
Name of Insured _____________________________ Effective Date: __________________

Are your present symptoms or conditions related to, or the result of:

Work related injury ☐ Yes ☐ No

Auto Accident ☐ Yes ☐ No

Other personal injury for which someone else may be legally responsible ☐ Yes ☐ No

If you answered yes to any of the questions above, please fill out the section below that applies to you.

Workman's Compensation (WC)

Claim # ____________________________ WC Insurananace Co. ____________________

Address ____________________________ City,State, Zip _______________________

Case Managers Name ____

Phone # _______________________________ Fax # _________________________

Date of Injury _______________________ Occupation _________________________

Employer at time of injury _______________________________ Phone_____________

Address ____________________________ City, State, Zip _______________________

Auto Accident

Date of Accident ___________________ Claim # _____________________________

Responsible Party/Insurer's Name ____

Insurance Company________________________________ Phone _________________

Address ____________________________ City, State, Zip _______________________

Attorney

Name ______________________________________ Phone __________________

Address ____

City_______________________________ State ________________ Zip_________

Legal Assignment of Benefits and Financial Agreement

I authorize payment of all medical benefits to Pain Treatment Centers of Illinois. I authorize the release of all medical information for the processing of medical payment. I acknowledge I am financially responsible for all services rendered to me and not covered by this assignment. I agree to pay Pain Treatment Centers of Illinois all fees and charges that may be incurred with the collection of my account including attorney fees and court costs.

Signature of Patient (or Guardian) ____

Date ________________________