



**REGISTRATION FORM**

Date: \_\_\_/\_\_\_/20\_\_

Home Telephone: \_\_\_/\_\_\_/\_\_\_ Mobile Telephone: \_\_\_/\_\_\_/\_\_\_

E-Mail Address: \_\_\_\_\_ SS# \_\_\_/\_\_\_/\_\_\_

Patient's Name: \_\_\_\_\_  
Last First Initial

Street Address: \_\_\_\_\_ APT# \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_/\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

How did you hear about us?  Newspaper  Seminar  TV  Friend \_\_\_\_\_

Family Doctor's Name: \_\_\_\_\_  Other \_\_\_\_\_

Doctor's Address \_\_\_\_\_ Doctor's Phone Number \_\_\_/\_\_\_/\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Street Address: \_\_\_\_\_ Telephone: \_\_\_/\_\_\_/\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
Last First Initial

Relationship to Insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Birth date: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_/\_\_\_/\_\_\_ Occupation: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Local #: \_\_\_\_\_

Street Address: \_\_\_\_\_ Telephone: \_\_\_/\_\_\_/\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip Code: \_\_\_\_\_

Please provide 2 alternate names and telephone numbers in case of an emergency:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: \_\_\_\_\_

I, the undersigned, have Insurance Coverage with \_\_\_\_\_

NAME OF INSURANCE COMPANY

And assign directly to Pinnacel Pain Management and/or Pinnacle Interventional Pain Associates, all medical benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

Patients/ Guardian Signature \_\_\_\_\_ Date: \_\_\_/\_\_\_/20\_\_

