**REGISTRATION FORM**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| (Please Print)  Today’s Date: / / Primary Care Physician: | | | | | |  | | | |
| **PATIENT INFORMATION** | | | | | |  | | | |
| Patient’s Last Name First Middle | | | | ❑  Mr. ❑ Miss  ❑ ❑ Ms.  Mrs. | |  | Marital Status (Circle One)  Single / Mar / Div / Sep / Widow | | |
| Is this your legal name?  ❑Yes ❑No | If not, what is your legal name? | | (Former Name) | | Birth Date  / / |  | Age | Race | Sex  ❑M ❑F |
| Street Address City State ZIP Code | | | | Social Security | |  | Cell Phone No: ( )  Other Phone No: ( ) | | |
| P.O. Box City State | | | | | | ZIP Code | | | |
| E- Mail: | | | | | |  | | | |
| Patient Occupation | | Patient Employer | | | |  | Employer Phone No.  ( ) | | |
| Employer’s Address City State | | | | | | ZIP Code | | | |
| Referring Physician | | Physician’s Address City State Zip Code | | | |  | Referring Physician Phone | | |

( )

**INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Is this patient covered  by insurance? ❑ Yes ❑ No | | | Name of Primary Insurance (if applicable): | | | | |
|  | | |  | | | | |
| Subscriber’s Name: | Subscriber’s S.S. # | Birth Date | | Policy # | Group # | Co-Payment |
|  |  | / / | |  |  | $ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient’s Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other | | | | | |
| Name of Secondary Insurance | | Subscriber’s Name | | Group # | Policy # |
| Patient’s Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other | | | | | |
| Is this a workers’ compensation  Injury? ❑ Yes ❑ No | | Adjuster Name: | | Adjuster Phone:  ( ) | |
| If W/C, claim #: | | Date of injury: | | | |
| Party Responsible for Bill | Birth Date  / / | Address (if different) |  | | Home Phone No.  ( ) |
| Is this person a patient here? ❑ Yes ❑ No | |  |
| Occupation Employer Employer Address | | | | | Employer Phone No.  ( ) |

**IN CASE OF EMERGENCY**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Local Friend or Relative (not living at same address) | Relationship to Patient | Home Phone No.  ( ) | Work Phone No.  ( ) |
|  |  |  |  |

* The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Optimal Pain & Regenerative Medicine or my insurance company to release any information required to process my claims.
* Optimal provides the opportunity for patients to communicate by email. By providing an electronic mail address to Optimal, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Optimal cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Optimal’s intentional misconduct.

X

PATIENT/GUARDIAN SIGNATURE DATE