CORVALLIS
pain management

REGISTRATION INFORMATION
PLEASE PRINT

PATIENT INFORMATION

Date: ___________ Name: ______________________________ Middle Initial: ____ Maiden: ________________

Male: _____ Female: _____ Birth Date: _____/_____/_____ Social Security #: __________________________

Home Phone: (____) ________________ Cell Phone: (____) ________________ Other: (____) ________________

Street Address: ____

City: ____ State: ________ Zip Code: _______________

Patient Employed By: _________________________________ Occupation: _______________________________

Emergency Contact: _______________________ Relationship: ______________ Phone : (____) _____________

Primary Insurance: ___________________ Policy #: ______________________ Group #: _____________________

Name of Primary Care Physician: ____

Primary Care Office: _________________________________ Primary Care Phone #: (_____) ______________

Preferred Pharmacy: ___________________________________ Pharmacy Phone #: (_____) ________________

Confirmation calls are made two business days in advance in order to ensure you are given 24-hours to cancel/reschedule an appointment. Please list the best phone number at which to reach you: ______________________________________

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with ______________________________, and assign all insurance benefits to MD Patrick Rask, MD Kasia Iwan, NP Jarod Smith, NP Nancy Burgess, PA Jason Smith, or PA Lynn Wood, 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 authorize the named doctor to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

______________________________	______________________________	______________________
Responsible Party Signature	Relationship To Patient	Date