SOUTHWEST OHIO
PAIN INSTITUTE
Patient Care Education Research

REGISTRATION FORM

(Please Print)

Today's date:	Family Doctor

PATIENT INFORMATION

Patient's last name: First: Middle: Street address: City State Zip		Gender: ☐ M ☐ F Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	

Home phone: Cell phone:	Email: Social Security #	Nickname:

Employer Name	Employer Phone:		

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Referring Provider address and telephone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ UHC	❑ Anthem	❑ Aetna

❑ Alliance	❑ BWC	❑ Healthspan	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name and birthdate	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name and date of birth	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	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 Southwest Ohio Pain Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*