Hudson Valley
PAIN MANAGEMENT

PATIENT REGISTRATION

PATIENT INFORMATION:

SOCIAL SECURITY # _____ LAST NAME _____ FIRST NAME_____

DOB _____ MAILING ADDRESS: _____

STREET ADDRESS _____

CITY _____ STATE ___ ZIP CODE _____ REFERRING PROVIDER _____

HOME PHONE # _____ WORK PHONE # _____ CELL # _____ SEX: M F

EMAIL _____ PREFERRED METHOD OF CONTACT (EMAIL, PHONE, CELL) _____

EMPLOYER INFORMATION:

COMPANY NAME _____

ADDRESS_____ CITY_____ STATE:____ ZIP_____

GENERAL INFORMATION:

PROVIDER YOU SEE HERE:_____ MARITAL STATUS:_____ STUDENT? Y N

RESPONSIBLE PARTY AND BILLING ADDRESS IF DIFFERENT AND SEASONAL ALTERNATE ADDRESS:

NAME OF RESPONSIBLE PERSON (if other than self)_____

ADDRESS_____ CITY_____ STATE:____ ZIP_____

RELATIONSHIP_____ PHONE NUMBER_____ ALTERNATE PHONE NUMBER_____

ALTERNATE ADDRESS:_____ CITY:_____ STATE_____ ZIP_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

INSURANCE INFORMATION: PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY

IS CONDITION RELATED TO EMPLOYMENT? Y N **AUTO ACCIDENT?** Y N **OTHER ACCIDENT?** Y N

1st INSURANCE NAME_____

SUBSCRIBER NAME _____ COPAY AMOUNT _____

ARE YOU? SELF SPOUSE CHILD OTHER DATE OF BIRTH FOR THE SUBSCRIBER (if NOT yourself) _____

2nd INSURANCE NAME _____

SUBSCRIBER NAME _____ COPAY _____

ARE YOU? SELF SPOUSE CHILD OTHER DATE OF BIRTH FOR THE SUBSCRIBER (if NOT yourself) _____

3rd INSURANCE NAME _____

SUBSCRIBER NAME _____ COPAY _____

ARE YOU? SELF SPOUSE CHILD OTHER DATE OF BIRTH FOR THE SUBSCRIBER (if NOT yourself) _____

ONE TIME AUTHORIZATION FOR MEDICARE AND THIRD PARTY INSURANCE CARRIERS

I authorize the release of any medical information necessary to determine my benefits and to process any claim for services provided. **Signature**_____ **Date** _____	I authorize CMS or my insurance carrier to forward payment for medical benefits for all services provided to my physician or medical group. **Signature**_____ **Date** _____