Hudson Valley
PAIN MANAGEMENT

PATIENT REGISTRATION

PATIENT INFORMATION:

LAST NAME:_____ FIRST NAME:_____MIDDLE INITIAL:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #: _____ SEX: M F

STREET ADDRESS:_____

CITY:_____ STATE:____ ZIP CODE:_____ REFERRING PROVIDER:_____

HOME PHONE #:_____ WORK PHONE #:_____ CELL #:_____

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

EMPLOYER INFORMATION:

COMPANY NAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

GENERAL INFORMATION: (OPTIONAL)

RACE:_____ ETHNICITY:_____ 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 **WORKERS COMPENSATION?** Y N

1st INSURANCE NAME:_____

SUBSCRIBER NAME:_____ CO-PAY AMOUNT:_____

PATIENTS RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER:_____

POLICY HOLDER'S DATE OF BIRTH: (if other than self)_____

2nd INSURANCE NAME:_____

SUBSCRIBER NAME:_____ CO-PAY AMOUNT:_____

PATIENTS RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER:_____

POLICY HOLDER'S DATE OF BIRTH: (if other than self)_____

3rd INSURANCE NAME:_____

SUBSCRIBER NAME:_____ CO-PAY AMOUNT:_____

PATIENYS RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER:_____

POLICY HOLDER'S DATE OF BIRTH: (if other than self)_____

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** _____