



# PATIENT REGISTRATION FORM

**\*please review and update the information below to the best of your ability\*\***

## DEMOGRAPHIC

### INFORMATION - PLEASE PRINT:

**Name:**

**Home Phone:**

**Mobile Phone:**

**Preferred contact: Home/Mobile**

**Address:**

**City:**

**State:**

**Zip Code:**

**Sex: M/F**

**Date of Birth:**

**Social Security No.:**

**Patient Email:**

**Required by government mandate (although you may refuse)**

**Language:**

**Race:**

**Ethnicity:**

### PRIMARY INSURANCE INFORMATION:

**Insurance Plan Name:**

**Member ID #:**

**Group #:**

### SECONDARY INSURANCE INFORMATION:

**Insurance Plan Name:**

**Member ID #:**

**Group #:**

### EMPLOYER INFORMATION:

**Employer:**

**Address:**

**Phone:**

**To the best of my knowledge the above information is complete and accurate.**

**Signed: \_\_\_\_\_ Date: \_\_\_\_\_**

**\*\*Please initial EACH item below\*\***

**ACKNOWLEDGEMENT AND AUTHORIZATION:**

**I have read and understand the HIPPA/Privacy Policy for CAMP INTERVENTIONAL PAIN ASSOCIATES PLLC.**

**Initial:** \_\_\_\_\_

**I hereby assign my insurance benefits to be paid directly to the healthcare provider.**

**Initial:** \_\_\_\_\_

**I authorize CAMP INTERVENTIONAL PAIN ASSOCIATES PLLC to release medical information required to process my claim.**

**Initial:** \_\_\_\_\_

**I have read and understand the Financial Policy for CAMP INTERVENTIONAL PAIN ASSOCIATES PLLC.**

**Initial:** \_\_\_\_\_

**I authorize CAMP INTERVENTIONAL PAIN ASSOCIATES PLLC to obtain/have access to my medication history.**

**Initial:** \_\_\_\_\_

**I authorize my providers office to contact me by mobile/home phone.**

**Initial:** \_\_\_\_\_



# HIPPA Authorization Form

**CAPTION**

**EMERGENCY CONTACT INFORMATION:**

**Name:**

**Relationship to patient:**

**Phone:** \_\_\_\_\_ **home/mobile (circle one)**

**I AUTHORIZE THAT MY INFORMATION CAN BE RELEASED TO THE FOLLOWING:**

**Name:**

**Relationship to Patient:**

**Phone #:**

**Name:**

**Relationship to Patient:**

**Phone #:**

**I AUTHORIZE THAT THE FOLLOWING CAN MAKE CHANGES TO MY INFORMATION:**

**Name:**

**Relationship to Patient:**

**Phone #:**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_