AINSWORTH INSTITUTE OF PAIN MANAGEMENT

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PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____

Social Security #: _____ Sex: M F

Home Phone #: _____ Cell Phone#: _____

Work Phone#: _____ Email: _____

Address: _____ City:_____ State:_____ Zip:_____

Primary Care Physician: _____

Office Address:_____

Work#: _____ Fax#: _____

Referring Physician (if different): _____

Office Address:_____

Work#: _____ Fax#: _____

Pharmacy: _____ Address:_____

Work#: _____ Fax#: _____

Insurance card# (for prior authorizations, if required): _____

Emergency Contact: _____ Relationship: _____

Phone#: _____

INSURANCE

Primary Insurance:_____

ID#: _____ Group#: _____

Secondary Insurance:_____

ID#: _____ Group#: _____

Insured Person (if not patient): _____

Work Phone#: _____ Fax#: _____

Address: _____ City:_____ State:_____ Zip:_____

*Patient Name*_____

New Patient Visit Questionnaire cont.

No-Fault Insurance

Carrier Name:_____ Phone Number:_____

Address: _____ Policy Holder: _____

Policy #: _____ Carrier Case #: _____

Worker's Compensation

Employer Name: _____ Phone Number: _____

Address: _____

Insurance Carrier: _____ Phone Number: _____

Address: _____

Policy #: _____ Case #: _____

AUTHORIZATION

I authorize the release of any medical information necessary to determine my benefits and to process any claim for services provided. I permit a copy of this authorization to be used in place of the original

_____ _____

Signature (Patient or Legal Representative) Date

ASSIGNMENT OF BENEFITS

I authorize *Corey W. Hunter, MD, PLLC* to apply for benefits on my behalf for covered services rendered. I request that payment from CMS or my insurance carrier to forward payment for medical benefits for all services be made directly to *Corey W Hunter, MD PLLC*.

I certify that the information I have provided with regards to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization my be evoked by either me or my insurance provider at any given time with proper written notice.

_____ _____

Signature (Patient or Legal Representative) Date