**REGISTRATION FORM**

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT INFORMATION**

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ GENDER: MALE FEMALE SOC SEC #: \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_

(MM DD YYYY)

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MI

WORK PH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL: CITY STATE ZIP

EMPLOYER’s NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: Single Married Divorced Widowed

PRIMARY CARE PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PH #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST FIRST MI

PREFERRED PHARMACY (name,location,phone,fax): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU LEARN ABOUT US? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**INSURANCE INFORMATION**

*PRIMARY INSURANCE POLICY*

INS. PLAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS. PLAN ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Policy Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. PLAN PH # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPECIALIST COPAY AMOUNT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP

PRIMARY INSURED’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY’S DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

LAST FIRST MI (MM DD YYYY)

PATIENT’S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*SECONDARY INSURANCE POLICY (IF APPLICABLE)*

INS. PLAN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS. PLAN ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Policy Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. PLAN PH # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPECIALIST COPAY AMOUNT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP

PRIMARY INSURED’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY’S DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

LAST FIRST MI (MM DD YYYY)

PATIENT’S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Printed Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient’s Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_

\***Legal Representative’s Printed Name**\_\_\_\_\_\_\_\_\_\_\_\_\_**Legal Representative’s Signature**\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_

*If representative, specify relationship to the patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *\*Note: Proof of legal authority may be required for legal representatives.* \*If signing as the legal representative, I represent to that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to North Texas Comprehensive Spine And Pain Center.