

# REGISTRATION FORM



FOUNDATION  
PAIN & SPINE

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (please print)

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Last Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Please list two confidential numbers we can leave message with and contact you by:

Cell Phone No: (\_\_\_\_\_) \_\_\_\_\_ Other Phone No: (\_\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Work Status:  Retired  Unemployed  Student  Full Time  Part Time

Patient Occupation: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Employer Phone No. (\_\_\_\_\_) \_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_

Patient's Relationship to Subscriber:  Self  Spouse  Child  Other \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's S.S. # \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Secondary Insurance (if applicable): \_\_\_\_\_

Patient's Relationship to Subscriber:  Self  Spouse  Child  Other \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Subscriber's S.S. # \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this a Workers' Compensation Injury? Yes No If Yes - Please see the front desk

Name of Emergency Contact: : \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Contact Phone No.: (\_\_\_\_\_) \_\_\_\_\_

FOUNDATION PAIN AND SPINE provides the opportunity for patients to communicate by email. By providing an electronic mail address to FOUNDATION PAIN AND SPINE, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. FOUNDATION PAIN AND SPINE cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by FOUNDATION PAIN AND SPINE intentional misconduct. Initial \_\_\_\_\_

By signing below, you confirm that the information you have provided is correct and true to the best of your knowledge. It is your responsibility to inform FOUNDATION PAIN AND SPINE of any changes to any information above.

\_\_\_\_\_  
Patient's or Authorized Representatives Signature

\_\_\_\_\_  
Today's Date