Patient Registration Form
Midwest Sports and Pain Specialists, P.C

Patient information (please print) **Today's Date:**________________________

Patient Name (last, first, middle)	Social Security #	Sex □ M □ F	Date of Birth	Maiden Name

Address	City/State/Zip	Marital Status □ Single □ Widowed □ Married □ Divorced

Home Phone # ( )	Cell / Pager # ( )

Employer (if retired, please indicate here)	Occupation	Employment Status □ Full-Time □ Part-Time

Employer Address	Employer City/State/Zip	Work Phone # ( )

Spouse Information

Spouse Name (last, first, middle)	Social Security #	Date of Birth

Address	City/State/Zip	Home Phone # ( )

Employer (if retired, please indicate here)	Occupation	Work Phone # ( )

Emergency Contact 1

Name (last, first, middle)	Home Phone # ( )	Work Phone # ( )	Relationship

Account Guarantor

Guarantor of Account (responsible party)	Relationship	Social Security #

Address	City/State/Zip

Employer (if retired, please indicate here)	Sex □ M □ F	Date of Birth	Home Phone # ( )

Employer Address	Occupation	Work Phone #

Primary & Secondary Insurance (attach copy of front & back of insurance cards)

Group Name	Group #	Member ID/ Policy #	Relationship	Effective Date

Employer Name	Employer Address	Employer City/ State/Zip	COPAY

Secondary Insurance Company Name	Subscriber Name	Subscriber Date of Birth	Social Security #

Group Name	Group #	Member ID/Policy #	Relationship	Effective Date

Employer Name	Employer Address	Employer City/ State/Zip	COPAY

Authorization for release of information

I authorize Midwest Sports & Pain Specialists, P.C to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Midwest Sports & Pain Specialists, P.C in writing of any information I do not want released.

X____

SIGNATURE DATE

Assignment of benefits

I authorize the assignment of benefits payable to Midwest Sports and Pain Specialists, P.C and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

Authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur.

Authorization for treatment

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

X____

SIGNATURE DATE