Patient Registration Form

Date: _____ Patient's Name: _____ Preferred Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Email: _____
Home Phone: _____ Mobile: _____ Work: _____
Social Security Number: _____ DOB: ____ / ____ / ____ Sex: ___ Marital Status: _____

Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ Native / Hawaiian / Other Pacific Islander ☐ White ☐ Other ☐ I prefer not to provide this information

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic or Latino ☐ I prefer not to provide this information
Preferred Language: _____
How did you hear about us? _____

EMERGENCY CONTACT INFORMATION:
Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Mobile: _____ Work: _____

INSURANCE INFORMATION:
Primary Carrier Name: _____ ID #: _____
Group #: _____
Address: _____
Policy Holder's Name: _____
Relationship: _____
Social Security Number: _____ DOB: ____ / ____ / ____
Employer Name: _____ Employer Phone Number: _____

Secondary Carrier Name: _____ Group #: _____
Address: _____
Policy Holder's Name: _____ Relationship: _____
Social Security Number: _____ DOB: ____ / ____ / ____
Employer Name: _____ Employer Phone Number: _____

I hereby authorize and consent to Alliance Pain Management's providers and other practice professional staff providing outpatient medical treatment, supplies, services, equipment, and other items related to my healthcare to me as determined to be necessary in their professional judgement. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

_____
Signature of Patient or Guardian

_____
Date

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