

# Pacific Coast Spine Institute and Pain Center

## REGISTRATION FORM

(Please Print)

Today's date:		<input type="checkbox"/> Work Comp		<input type="checkbox"/> Auto Accident		<input type="checkbox"/> Other	
<b>PATIENT INFORMATION</b>							
Patient's last name:				First:		Middle:	
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss		<input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Other:		Marital status (circle one): Single / Married / Divorced / Separated / Widowed / Domestic Partner / Other		Birth date:    /    /	Age:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Street address:		Social Security no.:		Home phone no.: (    )	
City:		State:		ZIP Code:		Cell phone no.: (    )	
Email address (please print clearly):							
Employer:		Employer phone no.: (    )		Empl. Fax no.: (    )			
Primary Care Physician:		PCP phone no.: (    )		PCP Fax no.: (    )			
Referred by:		<input type="checkbox"/> Dr.:		Ref Dr. phone no.: (    )		Ref Dr. Fax no.: (    )	
<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Yellow Pages	
						<input type="checkbox"/> Internet Search	
						<input type="checkbox"/> Other	
Ok to leave a message at your home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		On your cellphone? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		At your work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
Other family members seen here:							

### PHARMACY INFORMATION

Pharmacy:		Pharmacy phone no.: (    )		Pharmacy fax no.: (    )	
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### INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:		Birth date: /    /		Address (if different):		Home phone no.: (    )	
Relationship to Patient:		Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:		Employer:		Employer address:		Employer phone no.: (    )	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please indicate primary insurance:					
Subscriber's name:		Subscriber's S.S. no.:		Birth date: /    /	Group no.:	Policy no.:	Co-payment: \$
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:		Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	
						<input type="checkbox"/> Other	

### IN CASE OF EMERGENCY

Name of local friend or relative:		Relationship to patient:		Home phone no.: (    )		Work phone no.: (    )	
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