MISSION
advanced pain management & spine center

PATIENT REGISTRATION

Patient's Name:_____ DOB:_____ Sex:_____ Date of Illness/Injury: _____
Address: _____ City: _____ State: _____ Zip Code : _____
SS #: _____ Marital Status: _____ Preferred Language: _____ Race:_____
Name of referring doctor: _____ Phone #: (____)_____ ☐Not applicable
Employer: _____ Work Phone #: (____) _____
Address:_____ City: _____ State:_____ Zip Code: _____
Spouse's Name: _____ Spouse's Employer:_____
Address:_____ City: _____ State:_____ Zip Code: _____
Nearest relative not living with you: _____ Phone #: (____) _____

HEALTH INSURANCE COVERAGE

- To be completed by all patients. (In the case of workers' compensation, this information will only be used if your compensation is denied).

Health Insurance Company Name:_____ Effective Date: _____
Address: _____ City: _____ State: _____ Zip Code : _____
Phone #: (____) _____ Group #: _____ ID #: _____
Subscribe is: ☐Self ☐Spouse ☐Parent ☐Other Subscriber's Name: _____
Social Security # of Subscriber *(if other than self)*:_____ DOB of Subscriber: _____
Do you have secondary insurance? ☐Yes ☐No CarrierName: _____ ID#: _____

LIABILITY

-Please complete this section if your illness/injury is the result of an accident (auto or otherwise – but NOT work related). Please provide us with the med-pay/PIP benefits of your policy.

Insurance Company Name:_____ Date of Accident: _____
Address: _____ City: _____ State: _____ Zip Code : _____
Policy Number: _____ Claim #:_____
Claims Adjuster: _____ Phone #: (____) _____
Location of Accident (State):_____

PATIENT AUTHORIZATION AND ASSIGNMENT

I, _____, hereby authorize Mission Advanced Pain Manage-ment & Spine Center, P.C. (hereby referred to as MAPMSC), to apply for benefits on my behalf for services rendered. I request that payment be made directly to MAPMSC. I certify that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to my insurance companies. I permit a copy of this authorization an assignment to be used in place of original. This will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fees. I understand that MAPMSC may refer me to a facility in which it has a financial interest. I am not obligated to use that facility and may make my appointment at another one of my choice.

Date: _____ Signature: _____

*Providing your email address authorizes MAPMSC to send electronic correspondence to you. You may unsubscribe at any time. Revised 01/2016

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