LINCOLN.B. PAIN CLINIC, LTD.

COMPASSIONATE PAIN MANAGEMENT.

NEW PATIENT REGISTRATION

Name:_____._____._____
First Middle Last.

Address:_____
Street.(Not a P.O.Box).

_____ _____ _____
Zip Code City State.

Phone: _____ _____ _____
Home Cell Work

Birth Date_____SSN:_____ Sex_____ Marital Status_____

Employer:_____ Business Phone:_____
Guarantor/Spouse/Parent:_____ Relationship:_____
Address:_____ Birth Date:_____
SSN:_____ Emergency Contact:_____ Phone:_____
Do you have insurance?_____

INSURANCE INFORMATION

Primary Insurance_____
Subscriber_____ Policy#_____ Group#_____
Secondary Insurance_____
Subscriber_____Policy#_____Group#_____
Pharmacy_____ Phone_____ Location_____

IF YOUR INSURANCE REQUIRES AUTHORIZATION/REFERRAL YOU MUST HAVE IT AT THE TIME OF YOUR VISIT OR YOU WILL BE RESPONSIBLE FOR THE CHARGE.

Referring Physician_____ Required Laboratory:_____
Do you have a living will ?_____ Yes _____No

PATIENT RELEASE: I, THE UNDERSIGNED HAVE INSURANCE COVERAGE AS NOTED ABOVE AND ASSIGN DIRECTLY TO LINCOLN.B.PAIN CLINIC, LTD, ALL MEDICAL BENEFITS. I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO INSURANCE COMPANIES AND OTHER PHYSICIANS AS NECESSARY FOR FILINF MEDICAL CLAIMS TO THE PROVIDER. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL CHARGES NOT PAIN NY INSURANCE. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

Signature:_____ **Date**_____
Patient, Parent, or Guarantor.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO LINCOLN.B.PAIN CLINIC,LTD FOR ANY SERVICES FURNISHED ME BY A PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RLEATIED SERVICES.

Signature:_____ **Date**_____
Patient, Parent or Guarantor

Page 2. **NEW PATIENT REGISTRATION.**

Patient Name:_____ SSN#_____

May we leave any messages on your answering machine/voice mail ? Yes_____ No_____
May we leave any messages with members of household ? Yes_____ No_____

Please list three (3) emergency contacts (not residing in the same house):

Name:_____ Relationship:_____
Home telephone#_____ Cell#_____Work #_____

Name:_____ Relationship:_____
Home telephone#_____ Cell#_____Work #_____

Name:_____ Relationship:_____
Home telephone#_____ Cell#_____Work #_____

Signature:_____ Date:_____
Patient, Parent or Guarantor.