

# Freeman Pain Institute

## PATIENT REGISTRATION

**\*\*PLEASE PROVIDE US WITH COPIES OF ALL INSURANCE CARDS AND PHOTO ID\*\***

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Social Security: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_  
Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_  
Employer Address: \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_ Other Numbers \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_  
Primary Care Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance

**Primary Medical Insurance:** \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Policy No: \_\_\_\_\_

**Secondary Medical Insurance:** \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Policy No: \_\_\_\_\_

Relationship to Insured:  Self  Wife  Husband  Child  Other

Is this a workers' compensation, motor vehicle or a personal injury case? YES NO  
If YES please provide us with all information pertaining to your case

### Emergency Contact

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship \_\_\_\_\_

### Assignment of Benefits / Financial Responsibility

I hereby authorize Freeman Pain Institute, PA to furnish information to insurance companies or other physicians concerning my illness and treatments, and I hereby assign Dr. Freeman all payments for medical services rendered to me or my codependents. I hereby authorize Dr. Freeman, to provide diagnostic and therapeutic treatment considered medically necessary or advisable to myself, minor or dependant named above. Necessary forms will be completed to expedite insurance carrier payments, but I hereby acknowledge that I am responsible for all fees, regardless of insurance coverage. I agree to pay for services when rendered unless other arrangements have been made in advance and my failure to do so may result in additional fees to include attorney's collections and others as allowable by law.

Please be advised that "public law of the State of New Jersey mandates that a physician, chiropractor or podiatrist inform patients of any financial interests he or she may have in a health care service." Accordingly, I must inform you that I, Dr. Freeman have a financial interest in Linden Surgery Center, Linden, NJ and Middlesex Surgery Center, Edison, NJ.

I/we authorize payment of medical benefits to Dr. Freeman and I hereby further agree to guarantee payment to Dr. Freeman, for myself or any of my dependents. This is a lifetime authorization.

Patient / Responsible Party Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_