



FREEMAN PAIN INSTITUTE

Relieving your pain and restoring your life.

www.FreemanPainInstitute.com

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 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: __/__/__