Patient Registration

RPC
ROCKFORD PAIN CENTER, LTD.
2902 McFarland Road, Suite 202 • Rockford, Illinois 61107
ph 815.316.7300 • fax 815.654.1067

please complete both sides of this form

PHYSICIAN NAME

DATE

patient information *(please print)*

PATIENT NAME *(last, first, middle)*	SOCIAL SECURITY #	SEX ☐ M ☐ F	RACE	DATE OF BIRTH

ADDRESS	CITY / STATE / ZIP	COUNTY	MAIDEN NAME

RELATIONSHIP ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	HOME PHONE # ( )	CELL / PAGER # ( )	MAY WE CONTACT YOU BY EMAIL? ☐ YES ☐ NO	PRIMARY LANGUAGE

EMPLOYER *(if retired, please indicate here)*	OCCUPATION	EMAIL ADDRESS

EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP	WORK PHONE # ( )	EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME

spouse information

SPOUSE NAME *(last, first, middle)*	SOCIAL SECURITY #	DATE OF BIRTH

ADDRESS	CITY / STATE / ZIP	HOME PHONE # ( )

EMPLOYER *(if retired, please indicate here)*	OCCUPATION	WORK PHONE # ( )

emergency contact 1

NAME *(last, first, middle)*	RELATIONSHIP ☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ SON ☐ DAUGHTER ☐ FRIEND ☐ OTHER ☐ SPOUSE
HOME PHONE # ( )	
WORK PHONE # ( )	

emergency contact 2

NAME *(last, first, middle)*	RELATIONSHIP ☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ SON ☐ DAUGHTER ☐ FRIEND ☐ OTHER ☐ SPOUSE
HOME PHONE # ( )	
WORK PHONE # ( )	

account guarantor

GUARANTOR OF ACCOUNT *(responsible party)*	RELATIONSHIP ☐ SPOUSE ☐ PATIENT ☐ OTHER	SOCIAL SECURITY #

ADDRESS	CITY / STATE / ZIP	COUNTY

EMPLOYER *(if retired, please indicate here)*	SEX ☐ M ☐ F	DATE OF BIRTH	HOME PHONE # ( )

EMPLOYER ADDRESS	OCCUPATION	WORK PHONE # ( )

EMPLOYER CITY / STATE / ZIP	EMPLOYMENT DATE	CELL / PAGER PHONE # ( )

primary & secondary insurance *(attach copy of the front & back of insurance cards)*

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #

EMPLOYER NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP	COPAY

SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #

EMPLOYER NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER CITY / STATE . ZIP	COPAY

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

Authorization for release of information

I authorize Rockford Pain Center to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment of supplies provided to me for purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Rockford Pain Center in writing of any information I do not want released.

X _____

SIGNATURE

DATE

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Assignment of Benefits
I authorize the assignment of benefits to Rockford Pain Center and/or its designee for physician services and supplies by government and/or other private third party payer. I understand that I will be responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

Authorization for Additional Fees
In the event any lawsuit or action is brought to collect this account or any portion therefore, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur.

Authorization for Treatment
I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

X _____ | _____

SIGNATURE DATE