PINNACLE
PAIN AND SPINE

PATIENT REGISTRATION FORM

PATIENT INFORMATION		
Last Name:	**First Name:** **M.I.**	**Previous Name (If applicable):**
Date of Birth:	**Sex:** **Male** **Female**	**Social Security #**
Mailing Address:		**City/State/Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**
May we leave detailed messages regarding your medical care and test results?	**Email Address:**	
Marital Status:		
Race (please select): **White** **American Indian or Alaska Native** **Asian** **Hispanic** **Black or African American** **Native Hawaiian or Pacific Islander** **Other** **Decline**		**Ethnicity (please select one):** **Hispanic or Latino** **Not Hispanic or Latino** **Decline**
Preferred Language (please select one): **English** **Spanish** **Other:**		
Preferred Pharmacy Name & Location:		
Employer Name:		
Emergency Contact Name:	**Emergency Contact Phone:**	**Relationship to Patient:**

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor		
Last Name:	**First Name:**	**Relationship to Patient:**
Date of Birth:	**Social Security #**	**Phone:**
Responsible Party Address:		
City/State/Zip		

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	**Ins. Co Name:**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder Date of Birth:	**Policy Holder Date of Birth:**
Policy Holder Social Security #:	**Policy Holder Social Security #:**
Patient Relationship to Policy Holder:	**Patient Relationship to Policy Holder:**

I have read and agree to Pinnacle Pain and Spine Consultant's payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PPSC all money to which I am entitled for medical expenses related to the services performed from time to time by PPSC, but not to exceed my indebtedness to PPSC. I authorize PPSC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Pinnacle Pain and Spine is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PPSC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Pinnacle Pain and Spine's Privacy Notice ☐ **(Initials)**

Signature of Responsible Party: **x**_____ **Date:**_____

Printed Name of Responsible Party: **x**_____ **Date:**_____