COMPREHENSIVE CENTERS FOR PAIN MANAGEMENT
WEST CENTRAL SURGICAL CENTERS

☐ CC4PM-SYLVANIA ☐ CC4PM-BAYSIDE ☐ WCSC-CENTRAL AVE ☐ WCSC-BAYSIDE

PATIENT REGISTRATION FORM

Please complete all forms with blue or black ink only.

PATIENT INFORMATION:

LAST NAME:_____ FIRST NAME:_____MI: _____

ADDRESS: _____CITY:_____STATE:_____ZIP:_____

SS#:_____DOB:_____HOME PHONE: _____

Primary Physician:_____ Referring Physician:_____

Do you have access to a computer with internet? Yes No
Would you like your medical information accessible through the internet? Yes No

Your e-mail address: _____

RESPONSIBLE PARTY INFORMATION

LAST NAME:_____
FIRST NAME:_____ MI:_____

HOME PHONE:_____
ADDRESS:_____

WORK PHONE:_____
CITY:_____STATE:_____ZIP:_____

RELATIONSHIP TO PATIENT:_____
OTHER PARENT'S NAME:_____

PRIMARY INSURANCE NAME:_____
SECONDARY INSURANCE:_____

INSURED LAST NAME:_____
INSURED LAST NAME:_____

INSURED FIRST NAME:_____MI:_____
INSURED FIRST NAME:_____MI:_____

INSURED SSN:_____
INSURED SS#:_____

INSURED DOB:_____SEX:_____
INSURED DOB:_____SEX:_____

POLICY# /RID#:_____
POLICY# RID#:_____

GROUP#:_____
GROUP#:_____

EFFECTIVE DATE:_____
EFFECTIVE DATE:_____

EMPLOYER:_____
EMPLOYER:_____

EMERGENCY CONTACT INFORMATION:

NAME:_____
PHONE(S):_____

ADDRESS:_____CITY:_____ ZIP CODE:_____

RELATIONSHIP TO PATIENT:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

*I authorize the release of any medical information necessary to process my insurance claim(s). I also assign all medical and/or surgical benefits including major medical benefits, liability, auto accident, and Workers' Compensation, to which I am entitled, to **West Central Surgical Center and Toledo Pain Services.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. Even though I have provided all my insurance information, I understand I am financially responsible for any balance not covered by my insurance.*

MEDICARE – MEDICAID

I certify the information given be me in applying for payment is correct. I request payment of authorized benefits be made on my behalf.

Signature of Responsible Party:_____Date:_____

Signature of Responsible Party:_____Date:_____