



COMPREHENSIVE CENTERS
FOR PAIN MANAGEMENT

WEST CENTRAL SURGICAL CENTERS

CC4PM-SYLVANIA CC4PM-BAYSIDE CC4PM-ASPEN GROVE WCSC-CENTRAL AVE

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 PARENTS NAME: _____

PRIMARY INSURANCE NAME:

INSURED LAST NAME: _____

INSURED FIRST NAME: _____ MI: _____

INSURED SS#: _____

INSURED DOB: _____ SEX: _____

POLICY# /RID#: _____

GROUP#: _____

EFFECTIVE DATE: _____

EMPLOYER: _____

SECONDARY INSURANCE:

INSURED LAST NAME: _____

INSURED FIRST NAME: _____ MI: _____

INSURED SS#: _____

INSURED DOB: _____ SEX: _____

POLICY# RID#: _____

GROUP#: _____

EFFECTIVE DATE: _____

EMPLOYER: _____

EMERGENCY NOTIFICATION:

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 Worker's Comp., 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 that the information given be me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

Signature of Responsible Party: _____ Date: _____

Signature of Responsible Party: _____ Date: _____