



Lipson Pain Institute

RELIEVING PAIN • CHANGING LIVES

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PATIENT REGISTRATION PLEASE PRINT CLEARLY AND BRING TO YOUR FIRST APPOINTMENT OR SCAN AND FAX TO: 863-293-4410

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____ SS#: _____ - _____ - _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Sex: Male Female Date of Birth: _____ SINGLE MARRIED WIDOWED SEPARATED DIVORCED

How Did You Hear About Us? Web Site Phone Book Referred By A Friend, Who? _____

In Case Of Emergency, Who Should We Notify? Name: _____ Relationship: _____ Phone: _____

EMPLOYEE INFORMATION

Patient Employer: _____ Business Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SPOUSE / RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ SS#: _____ - _____ - _____

Person Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____ - _____ - _____

Street Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Responsible Party Employer: _____ Business Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

INSURANCE COMPANY COVERAGE INFORMATION

Patient Insurance Company: _____ Insurance Phone: _____

Policy Number: _____ Group Number: _____ Name of Subscriber: _____

SECOND INSURANCE COMPANY COVERAGE INFORMATION

Other Insurance Company: _____ Insurance Phone: _____

Policy Number: _____ Group Number: _____ Name of Subscriber: _____

PATIENT ASSIGNMENT AND RELEASE INFORMATION

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Ana D. Lipson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the aforementioned insurance company. I hereby authorize Dr. Ana D. Lipson to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship to Patient: _____ Date: _____