PIONEER SPINE AND SPORTS PHYSICIANS – PATIENT REGISTRATION

Last Name:_________________First Name:___________M.I.___DOB:___/___/____

Age:_______ Soc. Sec. #:_______-______-________ Sex: M ( ) F ( )

Address:_________________City:________________ State:______ Zip:__________

Home Phone:( )________________ Work Phone: ( ) ____________________

Cellphone:______________________ E-Mail:_______________________________

Emergency Contact:________________Relationship:________ Phone #: ( )_____
____

Employer: ____________________________ Phone#: ( )____________________

Workers Compensation Case ( ) M.V.A./Auto Accident ( )

Date of Injury: ______________ Date of Accident: __________________

BILLING INFORMATION

Primary Insurance:___________________ I.D. #:____________Group #:______________

Please fill out the following by placing a check next the correct answer ( )

Are You Participating In Physically Handicapped Childrens Program: Yes ( ), No ( )

Student Status: Full Time ( ), Part Time ( ), Not A Student ( )

Race: American Indian/Alaska Native ( ), Asian ( ), Black/African American ( ),
Native Hawaiian/Other Pacific Islander ( ), White ( ), Other ( ),
Patient Declined/Unknown ( )

Ethnicity: Hispanic/Latino ( ), Not Hispanic/Latino ( ), Patient Declined/Unknown ( )

Patient's Primary Language: English ( ), Spanish ( ), Arabic ( ), Polish ( ),
Portuguese ( ), Russian ( ), Vietnamese ( ), Patient Declined/Unknown ( ),
None ( ) Other: _____________

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CONSENT FOR TREATMENT

I authorize PIONEER SPINE & SPORTS PHYSICIANS, P.C. and/or their designee to examine, treat and perform any diagnostic testing or certain procedures in the office deemed necessary to properly evaluate my condition. I give consent to PIONEER SPINE & SPORTS PHYSICIANS, P.C. to retrieve and use my medication history form from SureScripts. I give consent to PIONEER SPINE & SPORTS PHYSICIANS, P.C. to send and retrieve my health information including without limitation consent to release office notes, diagnostic testing, labs, HIV test results, genetic test information, substance abuse information, and as otherwise required by law over the Massachusetts Health Information Highway, PVIX, SureScripts and other health information for the purpose of healthcare treatment.

____ Date:_______/________/_________
Patient or Empowered Representative

ASSIGNMENT OF BENEFITS

I authorize release of medical information necessary to process any and all claims for services rendered to me by PIONEER SPINE & SPORTS PHYSICIANS. This assignment will remain in effect until revoked by me in writing. I authorize payment of any and all benefits to be made on my behalf to the office of PIONEER SPINE & SPORTS PHYSICIANS. I understand that I am financially responsible for all charges. I have read this information and I understand its contents.

____ Date_______/________/__________
Patient or Empowered Representative

MISSED APPOINTMENT POLICY

If you miss an appointment and do not cancel the appointment ahead of time, this may be considered a "no show." Any missed appointment may be subject to a $20.00 missed appointment fee.

____ Date______/_______/____________
Patient or Empowered Representative

Attorney's Name (if applicable)

___________________________Address:__________________________________

Phone:_____________________________