255 Route 108, Somersworth, NH Ph (603) 692-3166
Fax (603) 692-3168

One Mound Court, Merrimack, NH Ph (603) 424-8866
Fax (603) 424-8868

2299 Woodbury Avenue, Newington, NH Ph (603) 431-3166

Patient Registration and Consent for Billing

Name (First, MI, Last)____

Mailing Address________________________ **Town/City/Zip**____________________

Phone Number (H)_______________ **(C)**_______________ **(W)**____________

DOB ____-____-_____ **SSN**_____-____-_____ **Sex M / F Marital Status S / M**

Contact In Case of Emergency ______________________________

Relationship____________________ **Daytime Phone**____________________

Primary Care Provider_______________ **Referring Provider**_________________

Insurance Information - Please complete fully. If Workers Comp, see below.

Primary Insurance ____________________ **ID#** ______________ **Group#** ______________

****Subscriber (Person Responsible for Insurance Card)****________________________

**** DOB**______________ **** SS#**________________ **** Employer**__________________

Referral needed for insurance? Yes / No Benefits Phone# (On back of Card) ____________

Secondary Insurance__________________________ **ID#** ____________________

Tertiary Insurance __________________________ **ID#** ____________________

Workers Compensation

Company____________________________ **Address**____________________________

Claim #____________________ **Date of Injury**__________ **Body Part Covered**__________

Case Manager ___________________ **Phone Number**____________________ **Ext**______

Employer at time of injury____________________ **Contact Name/Phone**______________

Attorney Name______________________________ **Phone**________________________

How did you hear about PainCare? **(Please circle)**

Friend/Relative PCP/Specialist Radio Newspaper

Phonebook Other_______________

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed carrier(s) and assign all insurance benefits otherwise payable to me for services rendered, directly to PainCare. I further understand I am financially responsible for claims denied or not covered by my insurance carrier for failure to obtain a referral or for any other coverage issues.

X___________________________________ Date_______________

Signature of Patient or Dependent

For office use:

PainCare Provider__________________ Date seen__________ Patient #_____________ Updated 1/21/08