Newport Interventional Pain Management

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	Mr. Mrs.	Miss Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? Yes No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: M F

Race/Ethnicity:	Language:	Cell phone no: ( )
Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone no.: ( )

Chose Morristown Gastroenterology, P.C. because/Referred to clinic by (please check one box):	Dr.	Insurance Plan	Hospital

Family	Friend	Close to home/work	Yellow Pages	Other

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? Yes No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? Yes No					
Please indicate primary insurance	Medicare	Blue Cross Blue Shield	Cigna	Aetna	BlueCare
United Healthcare	TennCare	Humana	Medicaid	Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	Self	Spouse	Child	Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	Self	Spouse	Child	Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. If we are a participating provider with your insurance, we will file the proper forms for reimbursement. If we are not or you do not have insurance, a minimum of $125.00 must be paid at check-in. Generally, everyone is responsible for a deductible, co-insurance, or a co-payment, which are required at check in. I also authorize Newport Interventional Pain Management LLC. or my insurance company to release any information required to process my claims.

To protect against possible transmission of blood-borne disease such as Hepatitis B/C or Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood while I am a patient. If, for example, an employee is stuck by a need while drawing blood or bodily secretions, I understand, and consent, that my blood, as well as the employee's blood will be tested. I further understand that my blood will not be routinely tested for these diseases and the results of any testing will be kept confidential.

Patient/Guardian signature *Date*

Please list the names/relationships of anyone we are authorized to speak with regarding your medical condition:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient/Guardian signature *Date*