
# Registration Form

(Please Print)

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|---|---|---|---|---|---|
| Today's Date: | | | PCP: | | |
| 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): | Birthdate: / / | | Sex: ☐ Male ☐ Female |
| Home Phone #: | | Cell Phone #: | | Work Phone #: | |
| Street Address: | City: | | State: | | Zip code: |
| Social Security #: | | | | | |
| Chose clinic because / Referred to Clinic by (please check one box): | | ☐ Doctor: | | ☐ Internet search | |
| ☐ Family | ☐ Friend | ☐ Close to home/work | ☐ Other | | |
| Other family members seen here: | | | | | |

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|---|---|---|---|
| The CMS (Centers for Medicare and Medicaid Services) requires that we ask these questions. You may decline to answer. | | | |
| Language: ☐ I decline to answer | Race: ☐ I decline to answer | Ethnicity: ☐ I decline to answer | |

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|---|
| Email Address: |
| Email address is only for use by Advanced PainCare (for notifications, surveys, etc) and will not be given or sold to anyone. |

| IN CASE OF EMERGENCY: | | | |
|---|---|---|---|
| Name of local friend or relative: | Relationship to patient: | Home Phone #: ( ) | Cell/Work Phone #: ( ) |

Patient / Guardian Signature

Date