COMPREHENSIVE
PAIN MANAGEMENT
of Central Connecticut

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PATIENT REGISTRATION INFORMATION

Patient Name: ____ □ Male □ Female
(Last) (First) (MI)

Date of Birth: ______________ Social Security #: ________________ Email: ______________________________

Address: __________________________ City: ________________ State: _________ Zip: __________________

Home Phone #: ________________ Work Phone #: ________________ Cell Phone #: ______________________

Referred by: ___________________________ Primary Care Physician: ______________________________

Marital Status: __________ Occupation: ____________ Emergency Contact Name: __________________________

Emergency Contact Phone: _______________________ Relationship to Patient: ____________________________

PRIMARY INSURANCE CARRIER INFORMATION

Insurance Company: ______________________ Name of Insured: ___________________________________

Insured's Sex: _____ Insured's Date of Birth: __________ Insured's Social Security #: ____________________________

Relationship to Insured: □ Self □ Spouse □ Child Insured's Employer: ______________________________________

Employer's Address: ____ Phone #: __________________________

Identification #: ______________________________ Group Name/ Number: ____________________________

SECONDARY INSURANCE CARRIER INFORMATION (ONLY IF APPLICABLE)

Insurance Company: ______________________ Name of Insured: ___________________________________

Insured's Sex: _____ Insured's Date of Birth: __________ Insured's Social Security #: ____________________________

Relationship to Insured: □ Self □ Spouse □ Child Insured's Employer: ______________________________________

Employer's Address: ____ Phone #: __________________________

Identification #: ______________________________ Group Name/ Number: ____________________________

For Medicare Patients:

I request that payment of authorized Medicare benefits be made on my behalf to **Comprehensive Pain Management of Central Connecticut, LLC.** for any medical services provided to me. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine benefits for payment of Medicare covered services.

Authorization and Assignment of Benefits:

I hereby authorize the assignment of payment directly to **Comprehensive Pain Management of Central Connecticut, LLC**. for medical benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by my insurance plan and I authorize Comprehensive Pain Management to release information required to support my claim.

Signature: ____

Date: ____