Solutions Pain and Spine Doctors
3780 Holcomb Bridge Rd, Ste D-1
Peachtree Corners GA, 30092
www.solutionspainandspine.com
Phone#470-641-6444, Fax- 770-343-7696

REGISTRATION FORM

DATE _____

PATIENT INFORMATION

DATE OF BIRTH: ____/____/_____ (MM DD YYYY) GENDER: MALE FEMALE SOC SEC #: _____-_____-_____

FULL NAME: _____ (LAST FIRST MI) HOME PH #: _____

WORK PH #: _____

ADDRESS: _____

CELL PH #: _____

_____ (CITY STATE ZIP) EMAIL:_____

EMPLOYER's NAME: _____

MARITAL STATUS: Single Married Divorced Widowed

PRIMARY CARE PHYSICIAN:_____

EMERGENCY CONTACT: _____ (LAST FIRST MI) PH #: _____

PREFERRED PHARMACY (name, location,- phone, fax):

_____

HOW DID YOU LEARN ABOUT US? _____

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INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

INS. PLAN NAME: _____ INS. GROUP # _____

INS. PLAN ADDRESS: _____ INS. ID # _____ (Policy Number)

_____ INS. PLAN PH # _____

_____ SPECIALIST COPAY AMOUNT: _____

CITY STATE ZIP

PRIMARY INSURED'S NAME: _____ (LAST FIRST MI) PRIMARY'S DOB: ____/____/_____ (MM DD YYYY)

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER_____

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SECONDARY INSURANCE POLICY (IF APPLICABLE)

INS. PLAN NAME: _____ INS. GROUP # _____

INS. PLAN ADDRESS: _____ INS. ID # _____ (Policy Number)

_____ INS. PLAN PH # _____

_____ SPECIALIST COPAY AMOUNT: _____

CITY STATE ZIP

PRIMARY INSURED'S NAME: _____ (LAST FIRST MI) PRIMARY'S DOB: ____/____/_____ (MM DD YYYY)

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER_____

Patient's Printed Name_____ Patient's Signature_____Date_____

***Legal Representative's Printed Name_____Legal Representative's Signature_____ Date_____**

*If representative, specify relationship to the patient_____ *Note: Proof of legal authority may be required for legal representatives.* *If signing as the legal representative, I represent to that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to Dallas Pain Institute.