Patient Information

Thank you for choosing Rockford Pain Management. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information.

Submit via Email

Today's date _____

First Name _____ M.I. _____ Last Name _____

Nick-name preferred: _____

Date of Birth _____ ☐ Male ☐ Female Soc. Sec # _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Occupation _____

Were you referred by ☐ Friend ☐ Insurance Carrier ☐ Physician ☐ Phone Book ☐ Advertisement ☐ Gift Certificate/Groupon ☐ Internet ☐ Attorney Workshop: ☐ Knee ☐ Fibro ☐ Pain

Referral Source? _____

Who is your family physician? _____ Phone # _____

Are you seeing the doctor due to a: ☐ Auto Accident ☐ Workman's Comp. Injury ☐ Personal Injury

Insurance Patients

	Primary Insurance	**Secondary Insurance**
Relation to Insured:	☐ self ☐ spouse ☐ child ☐ other	☐ self ☐ spouse ☐ child ☐ other
Complete the following insured information if *RELATION* is other than *SELF*.		
Insured's Name:		
Insured's Birthdate:		
Insured's Ins. ID:		
Group Number:		
Benefits Phone #:		

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate SCPC and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b) 4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits insurance of health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of doctor services.

Patient Signature: _____ Date: _____

Office Use: F/C: INS MC MD IO WC AA PI SP CCC# _____
Atchd: Insurance Card Claim Form Referral Event: _____