# MARYLAND PAIN AND SPINE CENTER, LLC
# REGISTRATION FORM

(Please Print)

| 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? | Social Security no: | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Email Address | Home phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

Ethnicity: Check one

❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Refused to Report ❑ Undefined

Race: Check one

❑ Asian ❑ Black or African American ❑ Other Race ❑ White

## FINANCIAL AUTHORIZATION AND RELEASE

I am ultimately responsible for payment of all charges for service rendered by Maryland Pain and Spine Center, LLC. For all contracted insurance carriers, I understand that I will be responsible for any **co-payments, deductibles, co-insurance** or any **services that are not considered medically necessary** by my insurance company and will be collected at the time of service.

I hereby authorize the release of pertinent medical information including the diagnosis and records of any treatment or examination rendered to me or my child, to my insurance carriers for the purpose of processing the claim.

I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing.

Signature of patient or parent if a minor (seal) Date

## HIPAA AUTHORIZATION

I acknowledge that I have been explained and/or reviewed this office's notice of Privacy Practices in accordance with HIPAA regulations:

Signature of patient or parent if a minor Date

I authorize Maryland Pain and Spine Center, LLC to use and disclose my health information to provide treatment or services to coordinate or manage my health care or for medical consultations or referrals.

Signature of patient or parent if a minor Date

********I hereby decline to authorize any release of my information to anyone other than my insurance:

Patient's signature: _____ Date

I hereby authorize this office to release my information to the following person(s):

Name. Phone Number Relationship

Name Phone Number Relationship

Maryland Pain&Spine Center LLC

We are interested in understanding more about your pain. Please help us by filling out this questionnaire. Please ***bring the completed questionnaire with you for your first appointment. Your appointment may be delayed if you do not arrive with the completed questionnaire. If you need assistance completing the form, contact the pain management center.***

Name_____ Date of Birth: _____

**Primary Care Physician:** **Referring Physician (if different):**

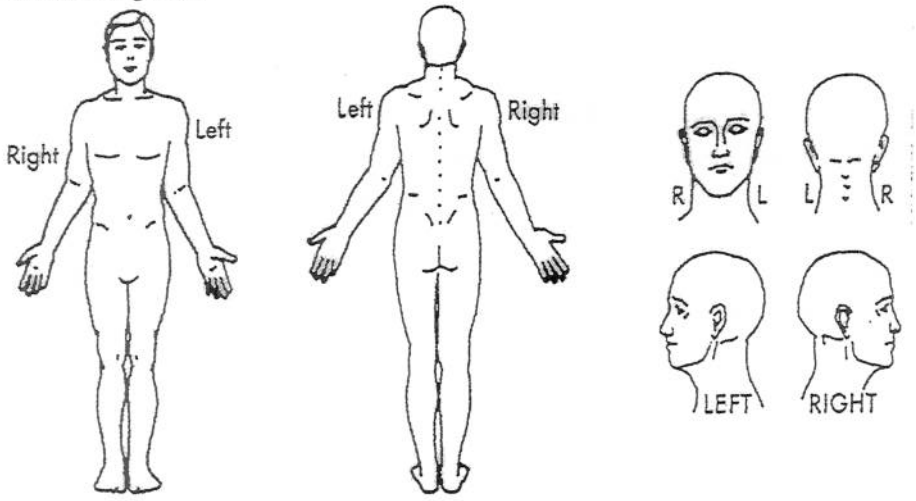
Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____

Have you ever been to a pain specialist before? ☐ YES ☐ NO If yes, list name of Physician/practice: _____ Phone:_____

When did you pain begin? _____

**Where is your pain?**

Please use the diagram below to indicate where your most painful areas are located. Shade in these areas darkly and shade in your less painful areas lightly. If the pain radiates of travels from one place to another, please include it on the diagram.




Using the scale below, please rate the level of your pain on a scale of 0 (no pain) to 10 (worst pain imaginable) for the following:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst pain imaginable)

**PRESENT** level of pain:_____ **WORST** level of pain you've had:_____ **LEAST** level of pain you've had:_____
Using the same scale (0-10), what level of pain is acceptable to you or tolerable for you? _____