Pinnacle
Pain Medicine

REGISTRATION FORM

(Please Print)

Today's Date ___/___/___ Primary Care Physician_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☑ Mr. ☐ Miss ☐ Ms. ☐ Mrs.	Marital Status (Circle One)
Block	Robert	Alan		Single / Mar / Div / Sep / Widow

Is this your legal name?	If not, what is your legal name?	(Former Name)	Birth Date	Age	Race	Sex
☑ Yes ☐ No			07/26/1968	44	W	☑ M ☐ F

Street Address	City	State	ZIP Code	Social Security	Cell Phone No: ( )
6827 Lotta Kay	Dallas	TX	75227	456533292	2147997775
P.O. Box	City	State	ZIP Code		Other Phone No: ( ) 2146877426

E-Mail:

Patient Occupation	Patient Employer	Employer Phone No.
HVAC Service Tech		( )

Employer's Address	City	State	ZIP Code
3006 Skyway Cir S.	Irving		

Referring Physician	Physician's Address	City	State	Zip Code	Referring Physician Phone
Andrew Park	Baylor Pavilion	Dallas			( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance?	Name of Primary Insurance (if applicable):
☑ Yes ☐ No	UMR

Subscriber's Name:	Subscriber's S.S. #	Birth Date	Policy #	Group #	Co-Payment $
SAME		/ /			

Patient's Relationship to Subscriber ☑ Self ☐ Spouse ☐ Child ☐ Other_____

Name of Secondary Insurance	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Is this a workers' compensation injury?	Adjuster Name:	Adjuster Phone:
☐ Yes ☑ No		( )

If WC, claim #:	Date of Injury:

Party Responsible for Bill	Birth Date	Address (if different)	Home Phone No.
Self	07/26/1968		( )
Is this person a patient here? ☐ Yes ☑ No			

Occupation	Employer	Employer Address	Employer Phone No.
			( )

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
Clarence Abner	Friend	(214) 799 1296	( )
Kimberly Schlueter	Sister	972 523 4986	

RP The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pinnacle Pain Medicine or insurance company to release any information required to process my claims.

RP Pinnacle provides the opportunity for patients to communicate by email. By providing an electronic mail address to Pinnacle, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Pinnacle cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Pinnacle's intentional misconduct.

X Robert Block 05/23/2013

PATIENT/GUARDIAN SIGNATURE DATE