Scott Integrated Pain Management, LLC

1601 Walnut Street, STE 522 | 215-825-5979 | tomscott@scottpain.com

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	Relationship to patient: _____
Address:	Date of Birth:
City: State:	
Zip:	Phone: _____ - _____
Home Phone:	Emergency Contact Information
Work Phone:	Name:
Mobile Phone:	Relationship:
Sex:	Phone:
Date of Birth:	Mobile Phone:( ) _____ - _____
Social Security No.:	
Patient email:	Employer information
Required by government mandate [although you may refuse]:	Employer:
Language:	Address:
Race:	Work Phone:
Ethnicity:	
Marital Status:	
Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

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ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for Scott Integrated Pain Management LLC**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize Scott Integrated Pain Management to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for Scott Integrated Pain Management**

Signed_____ **Date:**_____

- **I authorize Scott Integrated Pain Management, LLC to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____