Palmetto
Spine & Pain Care Consultants

Registration Information

(Please Print)

Date: ____/____/_____ Home Phone: _____

Patient Name: _____ _____ _____
Last First Middle Initial

Sex: ☐ Male ☐ Female Age: _____ Date of Birth: ____/____/_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Financial Information:

Patient's Social Security Number: ____/____/_____

Do you have Medical Insurance? ☐ No ☐ if Yes

#1 Insurance Co. Name: _____ ID#: _____

Subscribers Name: _____ Relation to Subscriber: _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Subscriber SSN: ____/____/_____ Subscriber Date of Birth: ____/____/_____

#2 Insurance Co. Name: _____ ID#: _____

Guarantors Information:

Name: _____ SSN: ____/____/_____

Patient Relationship: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In case of emergency, who do you want notified? _____

Relationship: _____ Home Phone: _____

Referring Provider: _____ Phone: _____

Primary Provider: _____ Phone: _____