ADVANCED INTERVENTIONAL PAIN CONSULTANTS
JAIME ROBLEDO, M.D.

REGISTRATION FORM

PATIENT INFORMATION						
Patient's last name: First: Middle:				Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐		
Is this your legal name? Yes No	If not, what is your legal name?	(Former name):	Date of Birth:	Age:	Sex: ☐ M ☐ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/referred to clinic by (Please check one box):		☐ Dr.		☐ Insurance plan	☐ Hospital	
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other		
Other family members seen here:		PCP:				

INSURANCE INFORMATION						
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.: ( )		
Is this person a patient here? ☐ Yes ☐ No						
Occupation:	Employer:	Employer address:		Employer phone no.: ( )		
Subscriber's name:	Subscriber's S.S. no:	Birth date:	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no: ( )	Work phone no.: ( )

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 Jaime Robledo, MD PA or insurance company to release any information required processing my claims.

Patient/Guardian signature *Date*