ADVANCED INTERVENTIONAL
PAIN CONSULTANTS

REGISTRATION FORM

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

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	

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*