North Texas Comprehensive Spine & Pain

100 Sara Swamy drive Suite 220 / www.shermanpain.com
Sherman Tx, 75090 Phone#903-892-1999, Fax- 903-892-6999

REGISTRATION FORM

DATE ______________

PATIENT INFORMATION

DATE OF BIRTH: ____/____/_____ GENDER: MALE FEMALE SOC SEC #: _______-______-________
(MM DD YYYY)

FULL NAME: ____ HOME PH #: __________________
LAST FIRST MI

WORK PH #: ___________________

ADDRESS: ____

CELL PH #: ____________________

____ EMAIL:_________________________
CITY STATE ZIP

EMPLOYER's NAME: ____

MARITAL STATUS: Single Married Divorced Widowed

PRIMARY CARE PHYSICIAN:____

EMERGENCY CONTACT: ____ PH #: _____________________________
LAST FIRST MI

PREFERRED PHARMACY (name, location, phone, fax):

____

HOW DID YOU LEARN ABOUT US? ____

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INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

INS. PLAN NAME: ____ INS. GROUP # __________________________

INS. PLAN ADDRESS: _____________________________________ INS. ID # _______________________________
(Policy Number)

____ INS. PLAN PH # _________________________

____ SPECIALIST COPAY AMOUNT: ________________
CITY STATE ZIP

PRIMARY INSURED'S NAME: _______________________________________ PRIMARY'S DOB: ____/____/_____
LAST FIRST MI (MM DD YYYY)

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER_________________________

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SECONDARY INSURANCE POLICY (IF APPLICABLE)

INS. PLAN NAME: ____ INS. GROUP # __________________________

INS. PLAN ADDRESS: _____________________________________ INS. ID # _______________________________
(Policy Number)

____ INS. PLAN PH # _________________________

____ SPECIALIST COPAY AMOUNT: ________________
CITY STATE ZIP

PRIMARY INSURED'S NAME: _______________________________________ PRIMARY'S DOB: ____/____/_____
LAST FIRST MI (MM DD YYYY)

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER_________________________

Patient's Printed Name__________________ Patient's Signature______________________Date_____________

***Legal Representative's Printed Name_____________Legal Representative's Signature___________ Date______**

*If representative, specify relationship to the patient______________________________ *Note: Proof of legal authority may be required for legal representatives.* *If signing as the legal representative, I represent to that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to North Texas Comprehensive Spine And Pain Center.