Barrington Pain and Spine Institute
600 Hart Road 3rd Floor Suite 300, Barrington, IL 60010; Tel: (847) 810-2000 Fax: 847-842-3708

REGISTRATION

Date_____ Home Phone_____ Work Phone_____ Email_____

Patient Last Name_____First Name_____ Initial_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐M ☐F Age_____ Birth date_____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Social Security #_____ Driver's License #_____

Insured Name_____How and where did you learn about this facility?_____
Last Name First Name Initial

Relationship To Insured ☐Self ☐Spouse ☐Child ☐Other

Condition/ Illness Related To ☐Illness ☐Employment ☐Auto ☐Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐Full-time ☐Part-time City _____ State _____ Zip_____Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____Phone_____ Occupation_____ City_____ State _____ Zip_____☐Full-time ☐Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐Yes ☐No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐Yes ☐No Pacemaker ☐Yes ☐No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Barrington Pain and Spine Institute all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and facility. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and facility any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and facility in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and facility to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and facility and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and facility in any attempts by such doctor and facility to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and facility against such insurers and/or employee health care plan in my name but at such doctor and facility's expenses. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date