ODYSSEY
PAIN CENTER

# PATIENT REGISTRATION FORM

22 Odyssey Suite 155
Irvine, CA 92618
(949) 207-7650

NEW PATIENT ☐ UPDATE ☐ Date:

## PATIENT INFORMATION

Patient Name ______________________________ Age _______ DOB ___________ Sex __________
Last First Middle

Address ______________________________

City ____________________ Zip ______________ E-mail ____________________

Home Phone #____________________ Cell Phone #____________________

Social Security ____________________

Emergency Contact ______________ ______________ ______________
Name Relationship Phone

Address ______________________________

Primary Care Physician ____________________ Phone ____________________

Referring Physician (if different from above) ____________________

How did you find us? ____________________

☐ Family/Friend ☐ Physician ☐ Insurance ☐ Website ☐ Other

## RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Name ______________________________ DOB ___________ Age ___________

Address ____________________ City ______________ Zip ___________

Home Phone #____________________ Cell Phone #____________________

Social Security ____________________ Driver's License # ____________________

Relationship to PT ____________________

## PRIMARY INSURANCE INFORMATION

Insurance Co Name ______________________________

Subscriber Name ____________________ DOB ______________

Identification No ____________________ Group No ____________________

Effective Date ____________________

## SECONDARY INSURANCE INFORMATION

Secondary Insurance Co Name ______________________________

Subscriber Name ____________________ DOB ______________

Identification No ____________________ Group No ____________________

Effective Date ____________________

## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Odyssey Pain Center to use this signature to release any information necessary to process and/or secure payment of benefits from any insurance or other payer designated or identified in the course of providing services; to allow a photocopy of my signature to be considered valid as the original and to be used for the period of lifetime. I hereby assign and authorize payment check(s) directly to Odyssey Pain Center for all payments to which I am entitled for services provided by Odyssey Pain Center. I understand that I am financially responsible for identified charges, and I agree to pay reasonable attorney fees, and/or collection fees, mediation fees and court costs incurred in the collection of my outstanding balance. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Responsible Party Signature ______________________________ Date ______________

Relationship to Patient ______________________________