PAIN MANAGEMENT ASSOCIATES P.A.
REGISTRATION FORM

Dr.Naveen Korivi

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)
					Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	Cell Phone 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	Online	❑ Other	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Address (if different):	Phone no.:
		( )

Car Insurance (if auto claim)	Adjusters name	Claim address:	Adjusters phone no.:
			( )
Claim no.			

Health Insurance Company	Phone no.	ID#	Group no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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 Pain Management Associates P.A. or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*