PrairieShore PAIN CENTER

185 Milwaukee Ave, Ste 230
Lincolnshire, IL 60069

847-883-0077 Phone
847-883-0078 Fax
PrairieShorePainCenter.com

Patient Registration

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call **(847) 883-0077** if you have any questions or are unsure how to complete any section of this form.

PATIENT INFORMATION

Your Name: _____

Date of Birth:_____ Age: _____ Height: _____ Weight: _____lbs

Street Address: _____

City:_____State: _____ Zip:_____

Email: _____ Gender: ☐ Male ☐ Female

Physical Address Same as Mailing? ☐ Yes ☐ No If not, please list mailing address:

Mailing Address: _____

City:_____State: _____ Zip: _____

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Work

Driver's License #:_____ State:_____ _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Race: ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ African-American ☐ Caucasian ☐ Refuse to Report

Ethnicity: _____ ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Primary Language: ☐ English ☐Other _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone Number:_____

Street Address: _____

City:_____State: _____ Zip:_____

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PRIMARY INSURANCE PLAN

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number:_____ Group Number: _____

Complete this area if you are not the Policy Holder for your PRIMARY INSURANCE

Insurance policy holder: ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: ____/____/____ Social Security Number: _____

SECONDARY INSURANCE PLAN (IF ANY)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this area if you are not the Policy Holder for your SECONDARY INSURANCE

Insurance policy holder: ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name:_____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: ____/____/____ Social Security Number: _____

WORKERS COMPENSATION CLAIM INFORMATION

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: _____

Agent Name: _____ State in Which Injury Occurred: _____

Phone Number: _____Fax Number: _____

Claim Number: _____ Date of Initial Injury: ____/____/____

INJURY CLAIM

Is your pain the result of a Motor Vehicle Accident or Personal Injury?) ☐ Yes ☐ No
(legal term describing injury sustained to your person by negligence of another)

I certify that the above information is accurate, complete and true. I give my consent for PrairieShore™ Pain Center to retrieve and review my medical history. I understand that this will become part of my medical record.

Patient Signature: _____ Date: ____/____/____