TMJ PAIN SOLUTIONS, SC
Patient Registration

PATIENT____ **DOB**____________ **DATE**__________

EMAIL____

AGE___________ SEX__________ MARITAL STATUS: M S W D SP

ADDRESS____ PHONE:_____________________

CITY ______________________________STATE________ZIP__________SS#________________________

EMPLOYER____ WORK PHONE:______________________

ADDRESS___________________________________ CITY____________________STATE_______ZIP_______

SPOUSE/GUARDIAN____ DOB ____________________

ADDRESS_________________________________CITY______________STATE________ZIP_______

EMPLOYER________________________________ PHONE:__________________________

ADDRESS_________________________________CITY______________STATE________ZIP________

PRIMARY INSURANCE____**Phone:**_______________________

ADDRESS_________________________________CITY_____________STATE_________ZIP_______________

POLICYHOLDER'S NAME_________________________RELATIONSHIP______________ DOB ___________

ID#______________________________________ GROUP #___________________________________

SECONDARY INSURANCE ____

ADDRESS________________________________CITY____________STATE__________ZIP_________

ID#__________________ GROUP #________________________ CERTIFICATE #________________

WORKMEN'S COMPENSATION ____

ADDRESS________________________________CITY____________STATE__________ZIP_________

PHONE TREATMENT AUTHORIZED BY

NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU ____

HOME PHONE______________________ WORK PHONE_____________________

ADDRESS________________________________CITY____________STATE__________ZIP_________

REFERRING DOCTOR____

ADDRESS____

PRIMARY DOCTOR____

ADDRESS____

DENTIST ____

ADDRESS____
(LIST ANY OTHER PROVIDERS YOU WOULD LIKE US TO CONTACT ON THE BACK OF THIS PAPER)