



Lake County Pain Management, Ltd.  
1880 W. Winchester Rd, Suite 101  
Libertyville, IL 60048-5321

## Registration

### Patient Information

_____		_____
(First, Middle, Last Name)		(Date of Birth)
_____		_____
(Address)		(City, State, Zip Code)
_____	_____	_____
(Home Telephone Number)	(Work Telephone Number)	(Cell Phone Number)
_____		_____
<u>REQUIRED</u> (Social Security Number)		(Prior Name)
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Student <input type="checkbox"/> Full-time Student <input type="checkbox"/> Other		

### Employment Information

_____		_____
(Occupation)		(Employer)
_____		_____
(Address)		(City, State, Zip)

### Spouse Information

_____		_____
(Name)		(Date of Birth)
_____		_____
(Social Security Number)	(Occupation)	
_____		_____
(Employer)		(Employer Phone Number)

### Person to Contact in Case of Emergency (Not Living in Home of Patient)

_____		_____	_____
(Name)		(Phone Number)	(Relationship to Patient)
_____		_____	
(Address)		(City, State, Zip Code)	

### How were you referred to our office?

- By a Doctor
- By an Attorney
- By a Patient
- Other

Please print the name of your source below.

\_\_\_\_\_

**Is your illness or injury related to any of the following?**

- Employment Injury
- Auto Accident
- Other Accident
- Other

**PLEASE PRINT DATE OF ACCIDENT/INJURY  
IN WHAT STATE DID THIS OCCUR?**

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**Consent to Treatment**

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment. I agree to the capture of a digital picture image of me for medical record identification.

**Financial Responsibility and Assignment of Benefits**

I agree to pay all charges for medical and health care services not covered by my insurance company. Payment by third party to be made directly to Lake County Pain Management, Ltd. (accepts assignment.) This may necessitate release of medical records to effect payment. I understand that these records may include but are not limited to examinations, treatments, prescription medications, diagnostic test, mental health, developmental disabilities, alcohol and drug abuse, and/or HIV/AIDS test results and/or information. Lake County Pain Management reserves the right to assess a 6% monthly interest on accounts not paid in a timely fashion.

**Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- Your records may be released in response to a subpoena, to the practice attorney, and/or the practice insurance carrier in the event of legal proceedings.

If you want to restrict the use of your healthcare information, please describe below. Lake County Pain Management reserves the right to refuse to abide by certain restrictions as described above: \_\_\_\_\_

**For Office Use Only:  Accepted  Declined Signed: \_\_\_\_\_**  
(For Lake County Pain Management)

**I certify that I have read this form and understand its contents. I certify that I have received a copy of the document titled "Notice of Health Information Practices" or that I was offered a copy and declined to take it.**

\_\_\_\_\_  
(Patient or Other Legally Authorized Person) \_\_\_\_\_ (Date)

\_\_\_\_\_  
(Witness) \_\_\_\_\_ (Date)