



**Midwest Joint Pain Institute, SC**  
10326 N Juliet Ct., Peoria, IL 61615

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Alternate Telephone \_\_\_\_\_

Email Address \_\_\_\_\_

Consent to receive informational newsletters via email: Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Pharmacy \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

I hereby assign, transfer and set over Center for Pain Management and Rehabilitation all of my rights, title and interest to my medical reimbursement benefit under my insurance policy. I authorize any release of medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. **I understand that I am financially responsible for all charges whether or not they are covered by my health insurance.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_