Integrated Spine Care
An Interventional Pain Practice

Gregory Gullo, M.D.
Phone (503) 261-6924
Fax (503) 261-6913

PATIENT REGISTRATION FORM

Family Physician:	**Date:**

Is treatment related to a work comp injury? **YES** **NO** ***If yes, Attending Physician:*** ____________

PATIENT INFORMATION

Patient Name: Last	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Referred by (please check one box): ❑ Dr. ____	❑ Other ____		Age:	Date of Birth:	Gender: ❑ M ❑ F
Address:		Social Security #:			Home phone:
City:	State:	Zip:			Cell Phone:
Occupation:	Employer:				Work Phone:

RESPONSIBLE PARTY

Name: Last	First	Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:
Address:		Social Security #:			Home phone:
City:	State:	Zip:			Cell Phone:
Occupation:	Employer:				Work Phone:

INSURANCE COVERAGE

Primary Insurance:		Phone:		
Billing Address, City, State, Zip:		ID #:		Group #:
Subscriber Name: Last	First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:
Employer:		Work Phone:		
Secondary Insurance:		Phone:		
Billing Address, City, State, Zip:		ID #:		Group #:
Subscriber Name: Last	First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:
Employer:		Work Phone:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Other phone:

The above information is true to the best of my knowledge. I understand I am financially responsible for any balance not covered by my insurance carrier.

MEDICARE - I request that payment of authorized medical benefits be made on my behalf to Gregory Gullo, MD, PC, for any services rendered to me. I hearby authorize Gregory Gullo, MD, PC, to release to the health care administrator and its agents any medical information needed to determine these benefits payable for related services under Title XVIII of the Social Security Act.

COMMERCIAL – I hearby authorize the release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHEWISE PAYABLE TO ME to Gregory Gullo, MD, PC.

Patient/Guardian signature: ____________ ***Date:*** ____________