

THE FLORIDA PAIN MANAGEMENT CENTER - STACY JOHN BERCKES, M.D.
PATIENT REGISTRATION FORM

Date _____ SS# _____ Drivers License # and State _____

First Name _____ Last Name: _____ Sex F M

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

DOB ___/___/___ Age _____ Marital Status: M S D W Spouse's name: _____

Email: _____ May we contact you via email? Yes No

OTHER HOME ADDRESS IF NOT FULL TIME FLORIDA RESIDENT AND DIFFERENT FROM ABOVE:

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

NEAREST RELATIVE NOT LIVING WITH YOU : Name: _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

PRIMARY /FAMILY PHYSICIAN: Name: _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

REFERRING PHYSICIAN : Physician's Name _____

Address: _____

City _____ State _____ Zip _____ Phone (_____) _____

EMPLOYER'S INFORMATION: Retired Yes No If no, Employer's Name: _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

If this injury regarding Auto Accident, Personal Injury or Worker's Compensation, please complete additional information on back of this page.

PRIMARY INSURANCE INFORMATION: Insurance Name: _____

Address: _____

City _____ State _____ Zip _____ Phone (_____) _____

Insured's Name _____ Sex F M DOB _____ Insured's relation to patient: _____

Policy # _____ Group Name/# _____ Group ID# _____

SECONDARY INSURANCE INFORMATION: Insurance Name: _____

Address: _____

City _____ State _____ Zip _____ Phone (_____) _____

Insured's Name _____ Sex F M DOB _____ Insured's relation to patient: _____

Policy # _____ Group Name/# _____ Group ID# _____

Medigap or Employer Supplemental

Signature _____ Date: _____

Please complete and return to The Florida Pain Management Center

Only complete this section if your injury is due to Auto, Personal Injury or Worker's Compensation accident:

WORKER'S COMPENSATION:

Claim/ID# _____ Date of Injury _____

Name of Employer through which this claim was filed _____

Insurance Company:

Name: _____ Telephone (_____) _____

Address _____ City _____ State _____ Zip _____

Dr. of Record _____ Tel (_____) _____

Case Worker's Name _____ Tel (_____) _____

AUTO ACCIDENT / PERSONAL INJURY

Date of Injury _____ State where accident occurred _____ Adjustor's name: _____

Insurance Co _____ Tel (_____) _____

Address: _____

Insured's Name _____ Policy/ID# _____

Attorney: _____ Telephone: (_____) _____

Complete
address: _____