SXM SYMPTOM MEDICINE™
Pain Medicine, Palliative Care, Anesthesia

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PATIENT REGISTRATION FORM

Welcome to Symptom Medicine. You have been referred to SXM by your physician for a medical evaluation. Sxm is a full spectrum pain medicine and symptom management clinic, specializing in anaesthesia, pain medicine, palliative care, symptom management and hospice. A comprehensive picture of your medical history, current medical condition, and understanding of clinic policies are important before commencing your care. Please note, before you can be considered for an appointment, the following are needed: physician referral, insurance pre-authorization, ability to pay, Patient Registration Form and medical records (H&P, progress notes, recent labs and diagnostic reports). Once all of this is done, we will send your New Patient Intake Packet. For additional information please email or call the clinic or visit our web site.

Patient Demographics		
Name:	Home Tel.	DOB
Address	Mobile Tel.	Age Male/Female
City State Zip	Work Tel	Marital Status
Primary Language	Email	Social Security No
Employer	Occupation	Title
Address	Work Hours per Week	Phone
Emergency Contact	Relationship	Tel.
Patient Representative	Relationship	Tel.

List all of the physicians or providers that you are currently seeing, and name all pharmacies you receive your medications from		
Referring Physician	**Speciality**	**Phone No**
Address		**Fax No**
Primary Care Physician	**Speciality**	**Phone No**
Address		**Fax No**
Other Physician	**Speciality**	**Phone No**
Address		**Phone No**
Other	**Speciality**	**Phone No**
Other	**Speciality**	**Phone No**

Pharmacy	**Address**	**Phone No**
Pharmacy	**Address**	**Phone No**

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PATIENT REGISTRATION FORM

Workman's Compensation		
Worker man's Compensation (WC) Carrier	Date of Injury (DOI)	Body Part Injured
Adjustor's Name	Adjustor's Tel	Claim No.
Have you filed a WC claim with this employer	Have you filed a WC claim before	Lawyer
WC Subscriber's Name on Insurance	Phone No	WC Pre-authorization No

Insurance and Finances		
Front and back copies of your insurance cards is required received yes no		
Insurance Company (primary)	Policy No	Group No.
Subscriber's Name on Insurance	Phone No	Insurance Pre-authorization No
Insurance Company and Phone No (secondary)	Policy No	Group No.
Subscriber's Name on Insurance	Phone No	Insurance Pre-authorization No
Financial Information		
Name on Credit Card	Credit Card No.	Exp Date
Name on Checking Account	Routing No.	Account No.

Reason for Referral		
Circle Your Complaints	**Services Requested**	**Patient Self Determination**
Anxiety Agitation Confusion Dementia Skin/Rash	☐ **New Pain Problem**	**DNR Yes No**
Ascites Pressure & Bed Sores Reduced Mobility	☐ **Cancer Pain &Symptoms**	**POLST FORM Yes No**
Weakness Debility Lymphoedema Breathlessness	☐ **Chronic Pain Management**	**Advanced Directives Yes No**
Shortness of Breath Cough Psychological Counseling	☐ **Hospice Patient**	**DPOA Yes No**
Support Depression Insomnia Nausea Vomiting	☐ **Medication and Rx**	**Health Care Proxy Yes No**
Diarrhea Constipation Anorexia Edema Pain	☐ **Pain Procedure/Injection**	**Patient Representative Yes No**
Medication Prescriptions	☐ **Symptom Management**	
Other	☐ **Other**	

Pain Complaint and Location	Special Needs

Signature	Date	Patient Name	Relationship
For Office Received		Ins Confirmed	Appt Date
PCP/ref letter sent		Payment Received	Appt confirmed w/ pt

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