

Plantar Fasciitis: Rt ____ Left ____ Bil ____

Achilles: Rt ____ Left ____ Bil ____

Shockwave Specialists of the Carolinas, LLC

Patient Registration Information

PATIENT INFORMATION			
Date	Treating Physician:	PCP Name:	
	Telephone No.: ()	Telephone No.: ()	
Patient's Last Name		First Name	Middle or Maiden
Mailing Address		City	State and Zip
Home Phone ()	Social Security #	Date of Birth	Sex M ___ F ___
Employer Name	Address	Phone ()	Occupation
Spouse or Parent's Name		Social Security #	Date of Birth
Emergency Contact Name		Contact Phone ()	Relation

INSURANCE INFORMATION (Please provide a copy of insurance card)

Insurance Claims Address	City/State/Zip	Insurance Co. Phone ()
Insurance ID #	Group Name and/or Number	
Policyholder's Social Security#	Policyholder's Date of Birth	
Secondary Insurance Co. Name	Policyholder's Name	Employer Plan ___Yes ___No
Insurance Claims Address	City/State/Zip	Insurance Co. Phone ()
Insurance ID Number	Group Name and/or Number	
Policyholder's Social Security #	Policyholder's Date of Birth	

****BILLING OFFICE USE ONLY****

Benefits:	Authorization/Referral
Copay: _____	Authorization# _____ By: _____
Deductible: _____ Met: _____	Auth required _____ Phone _____
OOP: _____ Met: _____	Fax# _____ Region _____
Pmt % _____ In Network _____ Out _____	ATTN: _____
Date verified: _____ Per _____	Eff Date _____ Pre-Existing _____
Verified By: _____	Primary / Secondary