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Diplomate in Neurology American Board of Psychiatry and Neurology

PATIENT REGISTRATION FORM

PLEASE ANSWER ALL QUESTIONS AND PRINT CLEARLY, THANK YOU

Patient Name ____ Age __________________ Sex ________

Last First Middle

Social Security ____ Primary Language ____________________________________

Address ____ City _______________ State _____________ Zip _____________

Phone No. _______________________________ **Birthdate** _________________ Marital Status S M W D

Occupation ____ Phone No. _______________________________

Employed by ____ Phone No. _______________________________

Address ____ City _________________ State _____________ Zip __________

Name of spouse ____ Social Security ____________________________________

Employed by ____ _____ Phone No.______________________________________

Address ____ City ________________ State ____________ Zip ________

Person to notify in case of emergency? _____________________________________ Relationship___________________________

Referred by ____ **Phone** ____

Family Doctor ____ **Phone** ____

INSURANCE INFORMATION

Medicare Insurance Information: Medicare Number: ____

Primary Insurance Company

____

Billing Address ____ City _______________ State _____________ Zip__________

Policyholder ____ Relationship___________________________________

Policy No. ____**Group No.** ____

Secondary Insurance - Name of company ____

Billing Address _______________________________________City _____________________ State ___________Zip____________

Policy Holder ____ Relationship_______________________________________

Policy No. ____Group No. ____

List all Medications That You Take:

____

List Any Drugs You Are Allergic To:

____

Reason for Seeking Doctor's Services: ____

List of other doctors treating you: ____

ASSIGNMENT OF BENEFITS SO THAT WE MAY FACILITATE PROCESSING OF ANY INSURANCE CLAIM FOR YOU.

1. I hereby assign to you, my doctor, all medical and surgical benefits to what I am entitled, including Medicare, Private Insurance and any other insurance plan.
2. I hereby authorize said assignee to release all information necessary to process this claim.
3. I understand that I am financially responsible for all charges whether or not paid by said insurance, including any deductibles and co-pays, and that payments are due at the time services are rendered.

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I CERTIFY THAT I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Signed: ____ Date ______________________________________