Patient Registration

PATIENT NAME: _____ _____ _____ DOB: ____/____/____

FIRST M.I LAST

SEX ☐ MALE ☐ FEMALE SSN:_____-_____-_____ DRIVERS LICENSE: _____

HOME PHONE: (____)_____-_____ CELL NUMBER: (____)_____-_____ EMAIL :_____

ADDRESS:_____

CITY: _____STATE: _____ZIP:_____

EMPLOYER:_____PHONE: : (____)_____-_____

SPOUSE/GUARDIAN: _____ _____

FIRST LAST

IF MINOR: GUARDIAN'S SSN: _____-_____-_____

PERSON TO CONTACT INCASE OF EMERGENCY:_____PHONE NUMBER: (____)_____-_____

REFERRING DOCTOR NAME: _____ _____

FIRST LAST

PHONE: (_____)_____-_____ FAX: (_____)_____-_____

PRIMARY CARE PHYSICIAN: _____ _____

FIRST LAST

PHONE: (_____)_____-_____ FAX: (_____)_____-_____

PRIMARY INSURANCE COMPANY

IF HMO NAME OF IPA/MEDICAL GROUP:_____

COMPANY:_____ PHONE: (____)_____-_____

SUBSCRIBER:_____DATE OF BIRTH: ____/____/____

RELATIONSHIP TO PATIENT: _____

I.D. # _____GROUP #: _____

SECONDARY INSURANCE COMPANY

COMPANY:_____ PHONE: (____)_____-_____

SUBSCRIBER:_____DATE OF BIRTH: ____/____/____

RELATIONSHIP TO PATIENT: _____

I.D. # _____GROUP #: _____

*****PLEASE READ CAREFULLY BEFORE SIGNING STATEMENT BELOW*****

ASSIGNMENT OF TREATMENT CONSENT, BENEFITYS & INSURANCE RELEASE OF INFORMATION

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicines, performance or operations and conduct laboratory, x-rays, or other studies that may be used by the attending doctor, or his nurse or qualified designate. I hereby assign authorized Medicare benefits and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either to me or my behalf to Neurosurgical Medical Clinic, Inc., for any services furnished to me by that physician. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I herby authorize said assignee to release all medical or financial information necessary to process any claim on my behalf. This information is to be used for medical billing purposes only.

DATE: ____/____/____ SIGNATURE: _____