PATIENT REGISTRATION

PATIENT NAME: ______________ ______________ ______________
FIRST M.I LAST

DATE OF BIRTH: _____ / _____ / ____ AGE: ___________ SEX: ☐MALE ☐FEMALE

DRIVERS LICENSE: ____________ SS# ______ - ______ - _____

HOME NUMBER: (_____) _____ - _____ WORK NUMBER: (_____) _____ - _____

ADDRESS: ______________________________

CITY: ______________ STATE: ______________ ZIP: ______________

EMPLOYER: ______________ WORK NUMBER: (_____) _____ - _____

ADDRESS: ______________________________ STE#: ______________

CITY: ______________ STATE: ______________ ZIP: ______________

SPOUSE/GUARDIAN: ____________ ____________ ____________
FIRST M.I LAST

IF MINOR: GUARDIAN'S SS# _____ - _____ - _____

PERSON TO CONTACT INCASE OF EMERGENCY: ________ PHONE NUMBER: ______________

REFERRING DOCTOR NAME: ______________ ______________
FIRST LAST

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

PRIMARY DOCTOR NAME: ______________ ______________
FIRST LAST

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

WORKERS COMPENSATION

DATE OF INJURY: _____ / _____ / _____ CLAIM #: ______________

EMPLOYER AT TIME OF INJURY: ______________

INSURANCE COMPANY: ______________

ADDRESS: ______________ CITY: ____________ STATE: _______ ZIP: __________

ADJUSTER: ______________

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

NURSE CASE MANAGER: ______________

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

*****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 of 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 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: ______________

GENEREALLY WE DO NOT ACCEPT LIENS, HOWEVER, THERE ARE OPTIONS AVAILABLE BASE ON INDIVIDUAL FINANCIAL CIRCUMSTANCE