

Adult Neurology Center - Patient Registration

Privacy Practice Notice: Given / Declined Date _____ Staff Initials _____

Patient Name _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Birth Date: _____ Age: _____ Sex: _____ SS#: _____

Relationship Status: Single Married Significant Other Separated Divorced Widowed

Spouse's Name: _____ Primary Phone: _____

Employer: _____ Occupation: _____

Preferred Pharmacy: _____

Pharmacy Address/Location: _____

Pharmacy Phone: _____

*Patient e-mail address: _____

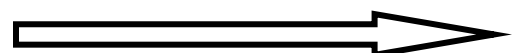
*Please send me a link to the Adult Neurology Center Patient Portal: Yes No

Primary Care Physician		Referring Physician	
_____	_____	_____	_____
First Name	Last Name	First Name	Last Name
_____		_____	
Phone Number _____		Phone Number _____	

Race	Ethnicity	Language
African American	Hispanic/Latino	English
Caucasian	Non-Hispanic	Spanish
Hispanic	Refuse to report	French
Asian		Russian
More than one race		Italian
Refuse to report		

Federal government regulation, as put forth through the Centers for Medicare and Medicaid, requires us to collect this information from each patient. Since we do not discriminate based on these factors, you can be assured that this will in no way negatively affect the medical care that you receive in this facility. We are merely adhering to government dictates. If you are opposed to reporting this information, simply check the "Refuse to report" box.

FORM CONTINUES ON THE OTHER SIDE – PLEASE COMPLETE



Primary Insurance Information

Name of Insurance

Specialist Co-payment Amount

Insurance ID Number

Insurance Group Number

_____/_____/_____
Insurance Effective Date

Subscriber's Name

_____/_____/_____
Subscriber's Birth Date

Subscriber's Relationship to the Patient

Is a referral required for this appointment? Yes No **If yes, please give a copy to the receptionist.**

Secondary Insurance Information

Name of Insurance

Specialist Co-payment Amount

Insurance ID Number

Insurance Group Number

_____/_____/_____
Insurance Effective Date

Subscriber's Name

_____/_____/_____
Subscriber's Birth Date

Subscriber's Relationship to the Patient

Is a referral required for this appointment? Yes No **If yes, please give a copy to the receptionist.**

Financially Responsible Party

(Complete only if the patient is under 18 years of age, a dependent college student, or is under a POA arrangement)

Name

Social Security #

Street Address

City

State

Zip Code

_____/_____/_____
Birth Date

Home Phone

Cell Phone

Relationship to the Patient