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