Adult Neurology Center - Patient Registration

Privacy Practice Notice: Given / Declined Date_____ Staff Initials_____

Patient Name_____ Date:_____

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

Address:_____

City:_____ State:_____ Zip Code:_____

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

Preferred Phone Number (please check one): ☐ Home ☐ Cell ☐ Work ☐ Other _____

*Patient e-mail address: _____

*By providing your e-mail address, you will receive e-mail notifications from Adult Neurology Center which may include the following; Appointment Reminder, Patient Note Notification, Patient Document Notification, Reminder Notification, Patient Billing Statement, or Portal Form Reminder.

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

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				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.

Relationship Status: ☐ Single ☐ Married ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name:_____ [Listing your spouse's name here does not give us permission to contact him/her. Please refer to the **Consent to Treat** page to indicate this permission.]

Employer:_____ Occupation:_____

Preferred Pharmacy:_____

Pharmacy Address/Location:_____

Pharmacy Phone:_____

Primary Care Physician

_____ _____
First Name Last Name

Phone Number _____

Referring Physician

_____ _____
First Name Last Name

Phone Number _____

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 Patient's Relationship to the Subscriber

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

MEDICARE PATIENT'S ONLY: PLEASE PROVIDE YOUR PRESCRIPTION COVERAGE

_____ _____
Name of Prescription Insurance ID Number

_____
Telephone Number on the Prescription Card

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 Patient's Relationship to the Subscriber

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

Rev: 01.21.17, 02.07.17, 05.05.17,09.10.17,01.10.18,02.07.18,3.14.19