

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	<input checked="" type="checkbox"/>	Ethnicity	<input checked="" type="checkbox"/>	Language	<input checked="" type="checkbox"/>
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

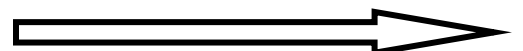
Phone Number _____

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