

PATIENT REGISTRATION FORM

NAME: _____ HOME PHONE#: _____

ADDRESS: _____
(street) (city) (state) (zip)

BIRTHDAY: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____ OCCUPATION: _____

EMPLOYER: _____ WORK PHONE: _____

FAMILY DOCTOR: _____ REFERRING DOCTOR: _____

EMERGENCY CONTACT: _____ PHONE #: _____

OK TO CONTACT ABOVE LISTED REGARDING YOUR MEDICAL CONDITION? YES NO

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER NAME, ADDRESS AND PHONE#: _____

GROUP #: _____ ID NUMBER: _____

SUBSCRIBER'S NAME: _____ BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____ S.S. #: _____

SECONDARY INSURANCE CARRIER NAME, ADDRESS AND PHONE #: _____

GROUP #: _____ ID NUMBER: _____

SUBSCRIBER'S NAME: _____ BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____ S.S. #: _____

ACCIDENT RELATED INSURANCE INFORMATION

(Please check one) WORKMAN'S COMPENSATION: _____ AUTO: _____ OTHER: _____

INSURANCE CARRIER NAME & ADDRESS: _____

ADJUSTER'S NAME: _____ PHONE #: _____

CLAIM NUMBER: _____ DATE OF ACCIDENT: _____

ATTORNEY'S NAME AND PHONE #: _____

I request payment of authorized Medicare and/or insurer benefits be made to me or on my behalf to Advanced Neurologic Care Associates, P.C. for services furnished to me by them. I authorize Advanced Neurologic Care Associates, P.C. to release to my insurance company any medical information needed to determine the benefits payable to related services. I understand I am financially responsible for any amount denied or partially paid by the Third Party Payor. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment. If we do not receive payment from you, finance charges will be assessed. Any court action that is necessary as a result of non-payment will be pursued in the jurisdiction where the services were rendered.