PATIENT REGISTRATION INFORMATION DATE_____

NAME_____
First Middle Last

ADDRESS_____CITY_____STATE_____ZIP_____

SOCIAL SECURITY#_____HOME PHONE_____

MARITAL STATUS _____SEX_____AGE_____DATE OF BIRTH_____CELL PHONE_____

RACE_____ ETHNICITY (circle one) Hispanic/Latino or Not Hispanic/Latino PREFER NOT TO ANSWER ❒

PREFERRED LANGUAGE (circle one) English Spanish Arabic Chinese Danish Dutch French Gaelic German Greek Hebrew Hindi Italian Japanese Malay Portuguese Russian Swedish Vietnamese Other_____

EMPLOYER_____OCCUPATION_____

WORK PHONE#_____

SPOUSE/PARENT NAME_____DOB_____PHONE_____

_____ _____ (_____) _____ - _____
Emergency Contact Name Relationship Emergency Contact Phone Number

PREFERRED PHARMACY_____ADDRESS_____
PHARMACY PHONE #_____ _____

REFERRED BY_____
NAME ADDRESS
FAMILY PHYSICIAN_____

GUARDIAN/PARTY RESPONSIBLE FOR ACCOUNT_____

Are you here due to an accident or injury? ☐ YES ☐ NO ☐ Work Related ☐ Auto Accident _____
If YES, Date of Injury_____ Name of Attorney/Case Manager

INSURANCE INFORMATION (Please show insurance card(s) to receptionist to copy)

PRIMARY		**SECONDARY**	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
ID#	GROUP #	ID#	GROUP #
NAME OF POLICYHOLDER	COPAY	NAME OF POLICYHOLDER	COPAY
RELATIONSHIP TO PATIENT	DOB	RELATIONSHIP TO PATIENT	DOB
SS#_____		SS#_____	

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment directly to Neurology LLP for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the release of any medical information needed to determine these benefits. I authorize the use of this signature on all insurance submissions. This authorization shall remain valid until written notice is given by me revoking said authorization.

Patient or Authorized Party Signature_____Date_____