Patient Registration

PATIENT NAME: _____ _____ _____ DOB: _____/_____/_____
FIRST M.I. LAST

SEX: ☐ MALE ☐ FEMALE SSN: _____-_____-_____ DRIVERS LICENSE #:_____

HOME PHONE: (_____) _____-_____ CELL NUMBER: (_____) _____-_____

ADDRESS:_____

CITY: _____STATE: _____ ZIP:_____ EMAIL:_____

EMPLOYER:_____PHONE: (_____) _____-_____

SPOUSE/GUARDIAN: _____ _____
FIRST LAST

IF MINOR: GUARDIAN'S SSN: _____-_____-_____

PERSON TO CONTACT INCASE OF EMERGENCY:_____ PHONE NUMBER:(_____)_____-_____

REFERRING DOCTOR NAME: _____ _____
FIRST LAST

PHONE: (_____) _____-_____ FAX: (_____) _____-_____

PRIMARY TREATING PHYSICIAN: _____ _____
FIRST LAST

PHONE: (_____) _____-_____ FAX: (_____) _____-_____

WORKERS COMPENSATION INFORMATION

DATE OF INJURY: _____/_____/_____ CLAIM #: _____

EMPLOYER AT TIME OF INJURY: _____

WORK COMP CARRIER: _____

ADDRESS: _____

ADJUSTER: _____ PHONE: (_____) _____-_____

NURSE CASE MANAGER: _____ PHONE: (_____) _____-_____

PLEASE READ CAREFULLY BEFORE SIGNING STATEMENT BELOW

ASSIGNMENT OF TREATMENT CONSENT, BENEFITYS & INSURANCE RELEASE OF INFORMATION

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicines, performance or operations and conduct laboratory, x-rays, or other studies that may be used by the attending doctor, or his nurse or qualified designate. I hereby assign authorized Medicare benefits and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either to me or my behalf to Neurosurgical Medical Clinic, Inc., for any services furnished to me by that physician. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance company or workers compensation. I herby authorize said assignee to release all medical or financial information necessary to process any claim on my behalf. This information is to be used for medical billing purposes only.

DATE: _____/_____/_____ SIGNATURE: _____