

PATIENT REGISTRATION FORM

Patient Information

First Name _____ MI _____ Last Name _____

Address (Street) _____

City _____ State _____ Zip Code _____

Home # _____ Birthdate _____ Sex Male / Female Marital Status S M D W

Social Security # _____ Employer _____ Work # _____

First and Last Name of Referring Physician _____ Phone # _____

Address of Referring Physician _____ City _____ State _____ Zip _____

First and Last Name of Primary Care Physician _____ Phone # _____

Address of Referring Physician _____ City _____ State _____ Zip _____

Name of Nearest Relative Not Living With You _____ Phone # _____

Billing Information (SPOUSE/PARENT/GUARDING) THIS INFORMATION IS REQUIRED - (THE INSURANCE CARD HOLDER)

Responsible Party (Insurance Card Holder) Full Name _____ Birthdate _____

Address _____ Home # _____

City _____ State _____ Zip _____

Social Security # _____ Employer _____

Work # _____ Employer Address _____

Insurance Information (Required) Copy of Insurance Card Required (Please fill this section in, even though we copy your card)

PRIMARY INSURANCE _____ Insurance Co. Phone # _____

Insurance Company Address _____

Policy or ID# _____ Group # _____

Insured's Name _____ Relationship _____

Secondary Insurance _____ Insurance Co. Phone # _____

Insurance Company Address _____

Policy or ID# _____ Group # _____

Insured's Name _____ Relationship _____

Industrial Information

Employer _____ Date of Injury _____

Insurance Carrier _____ Phone # _____

Address _____

Claim # _____ Authorized By _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Scottsdale Neurological Consultants to furnish information to my insurance carriers concerning my illness and treatments; I hereby assign to the Physician all payments for medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by the insurance agreement.

DATE _____

SIGNATURE _____