REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address:		
Email Address:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option): ○ [Doctor's name] ○ [Choose an item]

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: | Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neuroscience Specialists or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date