NEUROLOGY PARTNERS - REGISTRATION FORM
emasspineandbrain.com

Have your insurance cards & Drivers License out for receptionist - PLEASE FILL IN THIS FORM COMPLETELY

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street address:	P.O. Box:	City:	State:	ZIP Code:

Home phone no.: ( )	Cell phone no.: ( )	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Work phone no.: ( )	Employer:	Occupation:

Referred to clinic by: ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family / Friend ❑ Location ❑ Yellow Pages ❑ Other

Primary Care Physician	Primary Care Phone Number

Reason for Visit:	Is Visit Accident Related? ❑ YES ❑ NO	AUTO or Work Related? ❑ AUTO ❑ WORK	Date of Accident: / /

Is there an Attorney involved? ❑ YES ❑ NO	Attorney Name:	Attorney phone no.: ( )

GUARANTOR INFORMATION

Guarantor Name:	Guarantor Date of Birth	Guarantor Social Security #	Guarantor Drivers License/ID

Guarantor Address	State	Zip Code

HEALTH INSURANCE INFORMATION

Please Indicate **PRIMARY** Ins: ❑ Aetna ❑ Avmed ❑ Blue Cross ❑ Cigna ❑ Humana ❑ Medicare ❑ None ❑ Other

Subscriber's name:	Birth date: / /	Address (if different):	Home phone no.: ( )

Policy no.:	Group no.:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Insurance Telephone no.: ( )

Please Indicate **SECONDARY** Insurance: ❑ Aetna ❑ Avmed ❑ Blue Cross ❑ Cigna ❑ Humana ❑ Medicare ❑ None ❑ Other

Subscriber (if Different from Primary):	Birth date: / /	Address (if different):	Home phone no.: ( )

Policy no.:	Group no.:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Insurance Telephone no.: ( )

AUTO INSURANCE INFORMATION

Please Indicate **AUTO** Insurance: ❑ Allstate ❑ Direct General ❑ Geico ❑ Nationwide ❑ Progressive ❑ State Farm ❑ USAA ❑ None ❑ Other

Subscriber's name:	Birth date: / /	Address (if different):	Home phone no.: ( )

Policy no.:	Claim no.:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Adjuster Name & Telephone no.:

WORKER'S COMPENSATION INFORMATION

Name of Worker's Compensation Carrier:

Employer's Name (If different from above):	Employer's Address (if different):	Employer's phone no.: ( )

Claim no.:	Adjuster Name & Telephone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )	Cell 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 authorize Neurology Partners or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*