Lawrenceville Neurology Center Patient Registration Form

DATE: _____

NAME: _____
First Middle Initial Last

ADDRESS: _____
Street/Box Apt # City State Zip

PHONE: (___) _____ WORK: (___) _____ CELL: (___) _____

EMPLOYER: _____ OCCUPATION: _____

SEX: □ MALE □ FEMALE AGE: ____ DATE OF BIRTH: _____ SOC. SEC. #: _____

MARITAL STATUS: □ SINGLE □ MARRIED □ SEPERATED □ DIVORCED □ WIDOWED

SPOUSE'S / PARENT'S NAME: _____ CONTACT NUMBER: (__) _____

EMERGENCY CONTACT NAME: _____ CONTACT NUMBER: (___) _____

REFERRING DOCTOR: _____ PHONE NUMBER: (___) _____

ALLERGIES: Yes or No (please Circle and list, if any)_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
NAME OF INSURANCE

NAME OF INSURED: _____ INSURED'S DATE OF BIRTH: _____
MANDATORY

SECONDARY INSURANCE: _____
NAME OF INSURANCE

NAME OF INSURED: _____ INSURED'S DATE OF BIRTH: _____
MANDATORY

ACCIDENT INFORMATION

□ AUTO □ WORKMEN'S COMPENSATION DATE OF ACCIDENT / INJURY: _____

CASE MANAGER NAME/PHONE NUMBER: _____

ADJUSTERS NAME/PHONE NUMBER: _____

POLICY NUMBER: _____ INSURANCE COMPANY'S NAME/ADDRESS: _____

RELEASE OF INFORMATION / PAYMENT AUTHORIZATION/ASSIGNMENT OF BENEFITS/NO SHOW POLICY

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I assign direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance and that any payments due not covered by insurance over 120 days old will be charged a 15% late fee. I certify that the information I have reported to be correct. In addition, I understand that I may be billed a $25.00 no show fee for all missed appointments without prior notification.

_____ _____
SIGNATURE **DATE**