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REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:		First:		Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs.	Marital status (circle one)	
						Single / Mar / Div / Sep / Wid	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: / /	Age:	Social Security No.: / /	Home phone No.: ()	Cell phone No.: ()		
Street address:			City:	State	ZIP Code:		
Occupation:		Employer:		Employer phone No.: ()			

eMail:

If patient is a minor, please provide parent/guardian names and specify relation to the patient:

Referred to clinic by (please check one box):	<input type="checkbox"/> Dr. Name:
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Web Search <input type="checkbox"/> Ins. Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship:	Home phone No.: ()	Work phone No.: ()
Street address:	City:	State	ZIP Code:

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

If the patient is responsible for his/her bill, please skip the next section.

The guarantor is the person responsible for the patient's bill. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Person responsible for bill:	DOB: / /	Address (if different):	Home phone No.: ()
Occupation:	Employer:	Employer address:	Employer phone No.: ()
Work related?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Auto Accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, on what date did the injury occur? / /

Name of Primary Insurance:

Subscriber's name:	Birth date: / /	Group No.:	Policy No.:	Co-payment: \$
Patient's relationship to the subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

Name of Secondary Insurance (if applicable):

Subscriber's name:	Birth date: / /	Group No.:	Policy No.:	Co-payment: \$
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

PHARMACY

Pharmacy name:	Pharmacy Address:	Phone No.: ()
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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 **NeuroSpine Centers**, or insurance company to release any information required to process my claims.

Patient/Guardian signature

/ /

Date