

PATIENT REGISTRATION

(Please print information and give your insurance card to the receptionist so a copy can be made. Thank you.)

Name: _____
Address: _____ Zip: _____ City: _____ State: _____
Home Phone: _____ Work Phone: _____ Email: _____
Social Security #: _____ Date Of Birth: _____ Sex: _____
Employment Status: (Please circle) Full Time PartTime Retired Self Employed Unemployed
Employer: _____ Address: _____
Marital Status: (Please circle) Single Married Divorced Separated Widowed
Student Status: (Please circle) Full Time PartTime
Additional. Info: _____ Medication Allergies: _____
Next Of Kin: _____ Emergency Contact: _____ Phone: _____

Person who should receive bill (guarantor or responsible party):

Name: _____ Relationship To Patient: _____
Address: _____ Zip: _____ City: _____ State: _____
Home Phone: _____ Work Phone: _____ Email: _____
Social Security #: _____ Date Of Birth: _____ Sex: _____
Employment Status: (Please circle) Full Time PartTime Retired Self Employed Unemployed
Employer: _____ Address: _____

Profile Type: INSURANCE BILLING

Social Security #: _____ CoPay: _____ Primary Care Physician: _____

PRIMARY

Ins. Name: _____ Policy #: _____
Ins. Address: _____
Ins. Phone: _____ Group #: _____ Group Name: _____
Subscriber: _____ Date Of Birth: _____ Relationship To Patient: Spouse

SECONDARY

Ins. Name: _____ Policy #: _____
Ins. Address: _____
Ins. Phone: _____ Group #: _____ Group Name: _____
Subscriber: _____ Date Of Birth: _____ Relationship To Patient: _____

TERTIARY

Ins. Name: _____ Policy #: _____
Ins. Address: _____
Ins. Phone: _____ Group #: _____ Group Name: _____
Subscriber: _____ Date Of Birth: _____ Relationship To Patient: _____

I understand that I am responsible for my bill. I authorize TMHPO Department of Neurology to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to TMHPO Department of Neurology. I authorize release of information necessary to collect any payments to all my insurance companies. I further authorize release of medical information to any and all physicians involved in my care. I permit a copy of this authorization to be used in place of the original. I authorize the use of the "signature on file" to be used on all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance.

Signature Of Patient or Guardian _____ Date: _____