NEW PATIENT REGISTRATION

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PATIENT INFORMATION:

Name ______________________ Medical Record # ______________ Sex ☐ M ☐ F

Address ______________________ City ______________ State ______ Zip ______

Date of birth __________ Social Security # ______________ Marital Status ☐ Married ☐ Single ☐ Divorced

Phone ☐ Home ☐ Work ☐ Other ______________ Phone ☐ Home ☐ Work ☐ Other ______________

Referring Physician ______________________ Primary Physician ______________________

PATIENT EMPLOYMENT: ☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Phone ______________________ Employer ______________________

CONTACTS: ______________________ ______________________

______________________ ______________________

GUARANTOR: ☐ Same as patient

Name ____

Address ______________________ City ______________ State ______ Zip ______

EMPLOYMENT:

Employer ____

Phone ______________________ Phone ______________________

Social Security # ______________________ Date of Birth ______________________

PRIMARY INSURANCE: ☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party ____

Insured Phone ______________________ Company ______________________

Relationship to Patient ______________________ Social Security # ______________________

Insured ID ______________________ Policy Group ______________ Date of Birth ______________

SECONDARY INSURANCE: ☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party ____

Insured Phone ______________________ Company ______________________

Relationship to Patient ______________________ Social Security # ______________________

Insured ID ______________________ Policy Group ______________ Date of Birth ______________

I understand that I am responsible for all charges on my account regardless of insurance. I authorize payment of any benefits due from my insurance company to Raleigh Neurology Associates for services rendered to myself and/or my dependents.

Signature ____