PATIENT REGISTRATION

PLEASE PRINT

REFERRING DOCTOR: ______

Patient Name: ______ Date of Birth: ______

Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Social Security Number: ______

Employer: ______ Phone: ______ Ext: ______

Spouse/Parent Name: ______ Social Security Number: ______

Employer: ______ Phone: ______ Date of Birth: ______

Emergency Contact (a person not living at the same address.)

Name: ______ Relationship/Phone: ______

MEDICAL INSURANCE INFORMATION (Please give us your card so we may take a copy.)

Private Insurance Co: ______ Phone: ______

Insured Name: ______ Group: ______ ID: ______

Circle One: Motor Vehicle Work Injury Private Insurance

IF THIS A WORK RELATED INJURY OR A MOTOR VEHICLE ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

Insurance Co/Address: ______

Date of Injury: ______ Claim or Policy Number: ______

Adjuster/Agent Name: ______ Phone: ______

Employer when injured: ______

IF YOUR CLAIM IS IN LITIGATION, PLEASE COMPLETE THE FOLLOWING:

Attorney Name: ______ Phone: ______

FOR OUR RECORDS, PLEASE READ THE FOLLOWING AND SIGN BELOW WHERE INDICATED:

I hereby authorize the release of all medical information necessary to process claims and authorize my insurance company to make payments directly to Northwest Neurosurgical Associates I understand that I am personally responsible for any balance on my account regardless of insurance coverage and/or litigation that may be pending.

If I do not sign this agreement, I understand that payment will be made at time of service.

X Signature: ______ Date: ______

ATTENTION MEDICARE PATIENT'S, PLEASE READ AND SIGN THE FOLLOWING FOR MEDICAL BILLING:

I request that payment under the medical insurance program be made either to me or to the provider on any bills for services furnished to me and I authorize Northwest Neurosurgical Associates<None> to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare Claim. I further permit a copy of this authorization to be used in place of the original.

Patient's Signature: ______ Date: ______

FOR OFFICE USE: ACCOUNT NUMBER: ______