PATIENT REGISTRATION FORM

Patient's Social Security # _____ Sex: M/F_____ Date of Birth _____ Age _____

Patient's Name _____ Address _____

Apt # _____ City _____ State _____ Zip _____

Email Address _____

Race/Ethnicity _____ Preferred Language (if not English) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____ Employer's Phone Number _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Spouse Date of Birth _____ Spouse SS# _____

Spouse's Employer _____ Spouse's Employer Phone Number _____

Emergency Contact _____ Relationship _____ Phone _____

PHYSICIAN _____ Physician Phone Number _____

Physician's Address _____ City _____ State _____ Zip _____

PHARMACY NAME _____ **Pharmacy Telephone** _____

FINANCIAL INFORMATION (Person Responsible for Fees)

Subscriber Name _____ Relationship _____

Subscriber's Social Security # _____ Subscriber's Date of Birth _____

Subscriber's Address _____ City _____ State _____ Zip _____

Insurance Company _____ Claim Address _____

Insurance ID Number _____ Group Number _____

Secondary Insurance Company _____ Claim Address _____

Insurance ID Number _____ Group Number _____

Subscriber's Name _____ Subscriber Date of Birth _____ Relationship _____

Were you injured: in a motor vehicle accident? Y/N at Work? Y/N Have you informed your insurance carrier and/or employer? Y/N

Date of original injury _____ Claim/Policy # _____ Accident Insurance Carrier's Name _____

Accident Insurance Carrier's Address _____ City _____ State _____ Zip _____

Case/Claim Adjuster's Name _____ Case/Claim Adjuster's Phone Number _____

We'd like to know: Were MRI's or CAT scans taken? Y/N Where _____ When _____

Were other tests taken? _____

PLEASE READ:

- Copay is due at time of services. The patient is responsible for verifying insurance coverage if referred to any outside facility.
- I authorize payment of medical benefits to the Neuroscience Center of Northern New Jersey, PA
- I authorize Neuroscience Center of Northern New Jersey, PA to initiate a complaint to the Commissioner for any reason on my behalf.
- A photocopy of this shall be considered as effective and valid as the original.
- I voluntarily declined to supply information not provided above.

☐ I have received the Neuroscience Center of Northern NJ, PA brochure ☐ I have signed the PHI Form

Patient's Signature _____ Date: _____