Brain & Spine Specialists
Neurological Associates, Inc.

For Office Use Only

Chart #: _____

Doctor: _____

Registration Information

Date: _____

PATIENT INFORMATION (Email Address: _____)

Patient Name: _____ Preferred First Name: _____

Mailing Address: _____ City _____ State _____ Zip _____ County _____

Physical Street Address: _____ City _____ State _____ Zip _____

Home #: (_____)_____ Cell #: (_____)_____ Preferred Method of Contact: ☐ Telephone ☐ Email ☐ Text

Preferred Language: _____ Birth Date: ____/_____/_____ Social Security Number: _____-____-_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Race: ☐ Caucasian ☐ Asian ☐ Chinese ☐ Pacific Islander ☐ Native Hawaiian ☐ Filipino ☐ Black/African American ☐ American Indian/Alaska Native ☐ Undetermined

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other or Undetermined

EMPLOYER INFORMATION

Employer's Name _____ Work Number: (_____)_____ Occupation: _____

Mailing Address: _____City _____ State _____ Zip _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: _____ Policy Holder Name: _____ Relationship to the patient: _____

Employer Name: _____ Birth Date: ___/___/___ Social Security #: _____-____-_____

SECONDARY INSURANCE INFORMATION

Primary Insurance Company: _____ Policy Holder Name: _____ Relationship to the patient: _____

Employer Name: _____ Birth Date: ___/___/___ Social Security #: _____-____-_____

RESPONSIBLE PARTY (If patient is other than self)

Name: _____ Birth Date: ___/___/___ Social Security #: _____-____-_____ Relationship to the patient: _____

Mailing Address: _____ City _____ State _____ Zip _____ County _____

Physical Street Address: _____ City _____ State _____ Zip _____

Home #: (_____)_____ Cell #: (_____)_____

ACCIDENT INFORMATION (If applicable)

Is this a work related accident? ☐ Yes ☐ No Your Employer when injured: _____ Date of Injury: _____

Claim # _____ Claims Manager: _____ and Phone # _____

If Accident (Non-Worker's Comp) Please Complete: ____ Auto or ____ Other (describe): _____

Date of Accident: _____ Auto Insurance: _____ Insured's Name: _____

Policy #: _____ Attorney: _____ Phone #. : _____

PHYSICIAN INFORMATION

Referring Physician:_____ Address:_____ Phone #: _____

Primary Physician:_____ Address:_____ Phone #: _____

Preferred Pharmacy: _____ Address: _____ Phone #: _____

Patient Signature: _____ **Date:** _____