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 no 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 test 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: ______________