Neurosurgical Associates, Ltd

Patient Registration Form

PATIENT INFORMATION

Last Name | First Name | M

Birth Date __/__/____ Sex ☐M ☐F Social Security # _____

Address | Apt/Unit # | City | State | Zip

TELEPHONE CONTACT INFORMATION

Preferred Number

☐ Home Phone ___-___-____ Can we leave confidential messages regarding your care at this number? ☐ Yes ☐ No

☐ Mobile Phone ___-___-____ ☐ Yes ☐ No

☐ Work Phone ___-___-____ ☐ Yes ☐ No

AGE / MARITAL STATUS / EMAIL ADDRESS

Patient's Age

☐ Married
☐ Single
☐ Divorced
☐ Widowed
☐ Partner

Email Address

CURRENT WORK STATUS

☐ Full Time ☐ Unemployed ☐ Retired
☐ Part Time ☐ Disabled ☐ Self Employed

Employer

Job Title

PRIMARY CARE PHYSICIAN

Primary Care Physician Name | Clinic

REFERRING PHYSICIAN

Referring Physician Name | Clinic

PHARMACY INFORMATION

Pharmacy Name | Pharmacy Phone

Pharmacy Address

City | State | Zip

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Declined
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race/ Not Reported ☐ White

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported

Preferred Language

☐ English ☐ Chinese ☐ German ☐ Arabic ☐ Somali ☐ Japanese ☐ Korean
☐ Spanish ☐ Russian ☐ Vietnamese ☐ Other

What country were you born in?

Please continue on other side

IN CASE OF EMERGENCY

Last Name | First Name

Address

City | State | Zip

Emergency Contact's Phone # ___-___-____

Relationship: ☐ Spouse ☐ Daughter ☐ Son ☐ Mother ☐ Father ☐ Sister ☐ Other

PARENT / GUARANTOR INFORMATION

Last Name | First Name | M

Birth Date __/__/____ Age ____ Sex ☐M ☐F Social Security # _____-____-____

Address | Apt/Unit #: | City | State | Zip

Home Phone ___-___-____ Mobile ___-___-____ Preferred ☐ Home ☐ Mobile

Relation to Patient ☐ Parent ☐ Guardian ☐ Spouse ☐ Employer

INSURANCE INFORMATION

Related to an accident? ☐ **No** ☐ **Yes** **Date of injury?** __/__/____ ☐ **Workers Comp** ☐ **Auto** ☐ **Other**

PRIMARY INSURANCE

Please give your insurance card to the receptionist

Insurance Carrier

Subscriber ID | Grp

Address

City | State | Zip

SUBSCRIBER INFORMATION

Name | Sex ☐M ☐F

Birth Date __/__/____ | Relation

Address

City | State | Zip

SECONDARY INSURANCE

Insurance Carrier

Subscriber ID | Grp

Address

City | State | Zip

SUBSCRIBER INFORMATION

Name | Sex ☐M ☐F

Birth Date __/__/____ | Relation

Address

City | State | Zip

HIPAA DISCLOSURE INFORMATION (Please check all that apply. At least one option must be checked)

The Patient/Guardian authorizes Neurosurgical Associates to contact them at:

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email Address (patient portal account required)

The Patient/Guardian authorizes Neurosurgical Associates to:

☐ Leave a detailed voicemail message ☐ Leave a call back number only

Often times following surgery or appointments, it may be necessary for spouses, family members or others to receive/obtain medical health information or advice on your behalf. Please list two individuals who are authorized to receive/obtain information from Neurosurgical Associates (NSA). NSA reserves the right to contact or speak to others not listed on this list if we feel the situation is an emergency.

Neurosurgical Associates is authorized to disclose information about the patient to the following people:

Parents/Guardians of minors do not need to list their name(s) below

Spouse's Name:

Other/Name Relationship:

Other/Name: Relationship:

This Authorization will be in effect until patient revokes in writing.

Signature: _____ Date: _____