

PATIENT REGISTRATION FORM

Patient's Social Security # _____ **Date of Birth** _____
Patient's Name _____ **Sex** M / F **Age** _____
Address _____ **Apt #** _____ **City** _____ **State** _____ **Zip** _____
Home Phone _____ **Work Phone** _____ **Cell Phone** _____
Occupation _____ **Employer** _____ **Employer's Phone Number** _____
Employers Address _____ **City** _____ **State** _____ **Zip** _____
Spouse's Name _____ **Spouse's Date of Birth** _____ **Spouse's SS#** _____
Spouse's Employer _____ **Spouse's Employer's Phone Number** _____
Emergency Contact _____ **Relationship** _____ **Phone** _____
PHYSICIAN (1) _____ **Physician Phone Number** _____
Physician Address _____ **City** _____ **State** _____ **Zip** _____
PHYSICIAN (2) _____ **Physician Phone Number** _____
Physician Address _____ **City** _____ **State** _____ **Zip** _____
Pharmacy Name _____ **Pharmacy Telephone** _____

FINANCIAL INFORMATION (Person Responsible for Fees)

Subscriber's 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's 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 Adjustor's Name _____ **Case/Claim Adjustor's Phone Number** _____
We'd like to know: Were MRI's or CAT scan's taken? Y / N Where _____ When _____
Were other tests taken? _____

PLEASE READ:

- Copy is due at time of service. 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 have received the Neuroscience Center of Northern NJ, PA. brochure

I have signed the PHI form

Patient's Signature _____ **Date:** _____