Emerald Coast Center for Neurological Disorders

Patient Registration

Patient Information

Patient Name *(first, middle, last)* ______________________ Date of Birth ____________

SSN ____________ Maiden Name ____________ Sex ☐ *Male* ☐ *Female*

Address ______________________ City ____________ State ______ Zip ________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Email ______________________ Preferred Method of Communication ☐ *Phone* ☐ *Email*

Family Physician ______________________ Phone ____________

Employment Status *(circle one)* *Full-Time* *Part-Time* *Not Working* *Student*

Marital Status *(circle one)* *Single* *Married* *Divorced* *Widowed* *Separated* *Other*

Race *(check one or more)*
(Requested per CMS)

☐ *White / Caucasian*
☐ *American Indian / Alaska Native*
☐ *Pacific Islander / Native Hawaiian*
☐ *Other race*
☐ *Black / African-American*
☐ *Asian*
☐ *Hispanic / Latino*
☐ *Decline to answer*

Primary Language ______________________ ☐ **Allergic to Latex** ☐ **Allergic to:** ____________

Spouse's Name ______________________ Parent's Name *(if patient is minor)* ____________

Emergency Contact ____________ Relationship ____________ Phone ____________

Insurance Information

Primary Insurance Carrier

Insurance Provider ____________ Member ID # ____________ Group # ____________

Insured's Name ______________________ Insured's SSN ____________

Insured's Employer ______________________ Insured's Date of Birth ____________

Patient's Relationship to Insured *(check one)* ☐ *Self* ☐ *Spouse* ☐ *Dependent*

Secondary Insurance Carrier

Insurance Provider ____________ Member ID # ____________ Group # ____________

Insured's Name ______________________ Insured's SSN ____________

Insured's Employer ______________________ Insured's Date of Birth ____________

Patient's Relationship to Insured *(check one)* ☐ *Self* ☐ *Spouse* ☐ *Dependent*

Preferred Pharmacy (Name and Street):____

Emerald Coast Center for Neurological Disorders

How did you hear about our practice?

☐ *Physician referral (Name?)* ________________________

☐ *Friend referral (Name?)* ________________________

☐ *Advertising (Where?)* ________________________

☐ *Other (How?)* ________________________

Acknowledgment of Understanding

- I authorize the release of any information necessary to process insurance claims and to obtain reimbursement.
- I request that payment of authorized benefits be made on my behalf to Emerald Coast Center for Neurological Disorders. This assignment will remain in effect until revoked by me in writing.
- I understand that the *initial total bill only provides an estimate of insurance coverage* and is subject to actual reimbursement by my insurance.
- I understand I am financially responsible for *all* charges not paid by my insurance.
- I understand it is my responsibility to pay any deductible, co-pay or balance not paid by my insurance and that co-pay is due on the date of service.
- I understand there is a fee for any missed appointment which is not cancelled 24 hours in advance and must pay that fee prior to being able to schedule any future appointment. *(Fees are **$75** for a missed office appointment and **$250** for a missed procedure.)*

______________________________________ ______________________________________

Signature of Patient or Guardian *Date*

NOTE: Parents or legal guardian must sign for children under 18 years old.