

PATIENT REGISTRATION

PLEASE PRINT CLEARLY

EMAIL ADDRESS _____

Mr. Mrs. Miss Ms. Dr. Prof. Other _____ Single Married Other _____

PATIENT'S NAME (LAST, FIRST, MIDDLE)					HOME PHONE () ()
PATIENT'S HOME ADDRESS		APT. NO.	CITY	STATE	ZIP
					BUSINESS PHONE () ()
DATE OF BIRTH	SOCIAL SECURITY NUMBER		AGE	SEX	PHARMACY PHONE NUMBER () ()
PATIENT'S OCCUPATION		PATIENT'S EMPLOYER'S ADDRESS			CELL PHONE NUMBER () ()
SPOUSE'S NAME (LAST, FIRST, MIDDLE)			SPOUSE'S SOCIAL SECURITY NUMBER		BUSINESS PHONE () ()

PERSON TO NOTIFY IN CASE OF EMERGENCY	ADDRESS	CITY	STATE	ZIP	HOME PHONE () ()
RELATIONSHIP TO PATIENT					BUSINESS PHONE () ()

WHO IS YOUR PRIMARY CARE PHYSICIAN?	WHO IS YOUR PRIMARY CARE PHYSICIAN?	HOW DID YOU HEAR ABOUT US? (Include Names & Sources)
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MEDICARE—IS MEDICARE YOUR PRIMARY INSURANCE? YES NO

IDENTIFICATION NUMBER	WHICH DO YOU HAVE? PART A <input type="checkbox"/> PART B <input type="checkbox"/>	PLEASE INDICATE EFFECTIVE DATE _____ EFFECTIVE DATE _____
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PRIMARY INSURANCE

INSURANCE COMPANY NAME			
IDENTIFICATION NUMBER	SERVICE OR ENROLLMENT NO. OR GROUP NO.		EFFECTIVE DATE OF CONTRACT
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTHDATE	SUBSCRIBER'S RELATIONSHIP TO PATIENT	SUBSCRIBER'S EMPLOYER

SECONDARY INSURANCE

INSURANCE COMPANY NAME			
IDENTIFICATION NUMBER	SERVICE OR ENROLLMENT NO. OR GROUP NO.		EFFECTIVE DATE OF CONTRACT
SUBSCRIBER'S NAME	SUBSCRIBER'S BIRTHDATE	SUBSCRIBER'S RELATIONSHIP TO PATIENT	SUBSCRIBER'S EMPLOYER

WORKMEN'S COMPENSATION—IS THIS A WORKER'S COMPENSATION CLAIM? YES NO

IF SO, COMPANY NAME	DATE OF INJURY	CONTACT NAME	CONTACT PHONE () ()
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AUTO CLAIMS—IS THIS AN AUTO CLAIM? YES NO

IF SO, INSURANCE/RESPONSIBLE PARTY NAME	PHONE () ()	ATTORNEY
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"I authorize Mir Neurology and Spine Center to apply for benefits on my behalf or the services rendered by Dr. Mir and his staff. I request payment from my insurance or responsible party be made to Mir Neurology and Spine Center. I certify that all of the information I have provided is correct to best of my knowledge. I authorize the release of any medical information for this claim or any related claim. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for the medical services provided to me. I understand that payment is due when the statement is rendered. I have read and have received a copy of Mir Neurology and Spine Center's Notice of Privacy Practices."

PATIENT/GUARDIAN SIGNATURE _____ DATE _____