DERRY NEUROLOGICAL ASSOCIATES, PC
Patient Registration Form
(Please complete form in its entirety)

Patient Legal Name _____
Last First MI

Address _____

City, State & Zip:_____

Home Phone_____

Work Phone_____Cell_____

Birth Date _____/_____/_____ Sex: M F

Social Security #_____

Race: Black/Caucasian/Declined

Ethnicity: Hispanic/Non-Hispanic/Declined

Emergency Contact Name _____

Emergency Contact Tel.#_____

Primary Care Physician (PCP) _____

PCP's Address _____

City, State & Zip _____

PCP Telephone # _____

Pharmacy & Telephone # _____

Patient's email address: _____

Preferred method of contact? Phone/Email-WebPortal

Insurance Information:

Primary Insurance Company Name _____Effective Date _____

ID/Member #:_____

Group #_____

Claim/Case # _____

Date of Injury/Accident_____

Subscriber's Name _____

Date of Birth _____/_____/_____ Sex: M F

Subscriber's Social Security_____

Relationship to Patient: Self Spouse Parent Child

Subscriber's Employer _____

Telephone # _____

Employer's Address _____
Street City State Zip Code

Secondary Insurance Company Name _____ Effective Date _____

ID/Member # _____ Group# _____

I authorize the practice to submit claims to my insurance carrier and all unpaid balances will be the responsibility of the undersigned. If we are not notified of change(s) in insurance, you will be responsible if insurance does not pay. This includes fees associated with the collections of said balances (i.e., Collection Agency Fees, Attorney/Court Fees, etc.). I authorize the release of medical information necessary to process the claim. I also hereby authorize release and assign benefits otherwise payable to the practice. Obtaining referral authorization for your visit is the responsibility of the patient or responsible party.

I acknowledge receipt of privacy notice for this practice.

Signature:_____ Date: _____