



Neurosciences

PATIENT REGISTRATION FORM

PRIMARY CARE PHYSICIAN		WHO REFERRED YOU?		PREFERRED FIRST NAME	
LAST NAME			FIRST NAME		MIDDLE INITIAL
ADDRESS				DATE OF BIRTH	
CITY		STATE	ZIP CODE	HOME PHONE	CELL PHONE
SOCIAL SECURITY NUMBER		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		PATIENT EMAIL ADDRESS
PATIENTS EMPLOYER		OCCUPATION		WORK PHONE	
SPOUSE'S NAME		SPOUSE'S SOCIAL SECURITY NUMBER		SPOUSE'S DATE OF BIRTH	
SPOUSE'S EMPLOYER		SPOUSE'S WORK PHONE/EXT		SPOUSE'S CELL PHONE	

EMERGENCY CONTACT INFORMATION

NAME		RELATIONSHIP	CONTACT PHONE: CELL PHONE/HOME PHONE
------	--	--------------	--------------------------------------

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		SPECIALIST COPY	PHONE	
ADDRESS		CITY	STATE	ZIP CODE
ID # (POLICY NUMBER)		GROUP NUMBER		
SUBSCRIBER		RELATIONSHIP TO SUBSCRIBER	SUBSCRIBERS DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER		SUBSCRIBER'S SOCIAL SECURITY NUMBER		
SECONDARY INSURANCE COMPANY		SPECIALIST COPY	PHONE	
ADDRESS		CITY	STATE	ZIP CODE
ID # (POLICY NUMBER)		GROUP NUMBER		
SUBSCRIBER		RELATIONSHIP TO SUBSCRIBER	SUBSCRIBERS DATE OF BIRTH	
SUBSCRIBER'S EMPLOYER		SUBSCRIBER'S SOCIAL SECURITY NUMBER		

INSURANCE PAYMENT AUTHORIZATION AND RELEASE: I HEARBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO SSM MEDICAL GROUP AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY. I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICE ON THIS VISIT OR PREVIOUS ONE. I UNDERSTAND I CAN REQUEST ANOTHER COPY AT ANY TIME.

Authorized Signature: _____ **Date:** _____