MECKLENBURG NEUROLOGY

Registration Form

Date:_____**PCP**_____**Referring MD**_____

Last Name_____**First**_____**Middle**_____

DOB_____**Age**_____ **Sex** ☐ **Male** ☐ **Female**

Marital Status ☐ **Single** ☐ **Married** ☐ **Partner** ☐ **Divorced** ☐ **Widowed**

Street Address_____

City/St/Zip_____

SSN #_____**Phone**_____**Cell**_____

Employer_____**Work Phone**_____

Chose Clinic due to ☐ **Dr** ☐ **Insurance Plan** ☐ **Hospital Plan** ☐ **Other**

Insurance Information

Person Responsible for bill_____**DOB**_____

Address if different from above_____

Employer_____ **Phone**_____

Please indicate Primary Insurance_____**Phone**_____

Subscriber's Name_____**DOB**_____**SSN**_____

Policy_____**Group #**_____**Copay amt**_____

Patient's relationship to subscriber ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Secondary Insurance (if applicable)_____

Subscriber's Name_____**DOB**_____**SSN**_____

Phone_____**Policy**_____**Group #**_____

Patient's relationship to subscriber ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

In case of Emergency

Name of friend or relative not at same address_____

Relationship to patient_____**Phone**_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mecklenburg Neurology or the insurance company to release any information required to process my claims.

_____ _____

Signature/Guardian Signature **Date**

SUBMIT FORM