GHALY NEUROSURGICAL ASSOCIATES

Patient Registration Form

Today's Date: ______________________ **New** ________ **Estab** ________

Patient Information

Patient Name: First ______________ M: ______________ Last: ______________

Address ______________________________

City/State/Zip: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Date of Birth: ______________________________

Social Security: ______________________________

Gender: Circle One Male Female

Marital Status: Single Married Divorced Widowed

Spouse's Name (if applicable:) ______________________________

Spouse's Date of Birth: ______________ Spouse's Social #: ______________

If the patient is a minor, please complete the following information:

Mother's Full Name: ______________________________

Home Phone ______________ Work Phone: ______________

Father's Full Name: ______________________________

Home Phone ______________ Work Phone: ______________

Employer Information

Employer Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________________________

In case of an emergency, who should we contact on your behalf?

Contact Name: ______________________________

Relationship to Patient: Spouse Child Sibling Other: ______________

Address: ______________________________

City/State/Zip: ______________________________

Home Phone: ______________ Work Phone: ______________

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Please provide your primary care physician's name (PCP):

First: ____________________ Last: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone: ____________________

If you were referred by a physician OTHER than your PCP, please provide the following information:

First: ____________________ Last: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone: ____________________

Primary Health Insurance

Insurance Company Name: ____________________

Policyholder's Name: ____________________

Relationship to Patient: Self Spouse Child Other: ____________________

Employer of Policy Holder: ____________________

Social Security #: ____________________ Date of Birth: ____________________

Insurance ID # : ____________________

Insurance Group # : ____________________

Secondary Health Insurance

Insurance Company Name: ____________________

Policyholder's Name: ____________________

Relationship to Patient: Self Spouse Child Other: ____________________

Employer of Policy Holder: ____________________

Social Security #: ____________________ Date of Birth: ____________________

Insurance ID # : ____________________

Insurance Group # : ____________________

GHALY NEUROSURGICAL ASSOCIATES

Patient Registration Form

Consents and Authorizations

Release of Information: I authorize **GHALY NEUROSURGICAL ASSOCIATES** to release to my insurance company or its representatives, information including diagnosis and the records of any treatment or examination rendered to me that they may require to process my claim for benefits.

Authorization for Assignment of Benefits: I authorize and request that my insurance company pay directly to **GHALY NEUROSURGICAL ASSOCIATES** the amount due me in pending claims for medical treatments or services, by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.

Financial Agreement: It is understood that, whether I sign as patient or responsible party, I am directly responsible for services rendered which are not paid by insurance. I certify that to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify **GHALY NEUROSURGICAL ASSOCIATES** in case of any change in the information contained on this form.

I have read and agreed to the above consents and authorizations:

Patient Name (Please Print): ______________________________

Patient Signature: ______________________________ Date: ____________

If the patient is a MINOR, the parent or guardian should sign below:

Responsible Party (Please Print): ______________________________

Responsible Party Signature: ______________________________ Date: ____________