GHALY NEUROSURGICAL ASSOCIATES

Patient Registration Form

Today's Date:			New			Estab	
Patient Ir	nformation						
	Patient Name:	First			M:	Last:	
	Address						
	City/State/Zip:						
	Home Phone:						
	Cell Phone:						
	Date of Birth:						
	Social Security:		_		_		
Gender:	Circle One		Male	Female			
Marital S	tatus:	Single	Married	Divorced	Widowed		
	Spouse's Name (if appli	cable:)					
	Spouse's Date of Birth:				Spouse's Socia	al #:	
If the pat	tient is a minor, please com						
	Mother's Full Name:						
	Home Phon					ork Phone:	
	Father's Full Name:						
	Home Phon	e			Wo	ork Phone:	
Employer	r Information						
	Employer Name:						
	Address:						
	City/State/Zip:						
	Phone:						
In case of	f an emergency, who should	we conta	ct on your be	half?			
	Contact Name:						
	Relationship to Patient:	:	Spouse	Child	Sibling Ot	her:	
	Address:						
	City/State/Zip:						
	Home Phone:			Work Pho	ne:		

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Patient Registration Form

First:	Please provide your primary care physician's name (PCP):							
City/State/Zip: Phone: If you were referred by a physician OTHER than your PCP, please provide the following information: First: 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 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 Company Name: Policyholder's Name: Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth:	First:	irst: Last:						
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 Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth: Insurance Group #: Secondary Health Insurance Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth: Insurance Company Name: Policyholder's Name: Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth:	Address:							
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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:	City/State/Zip:							
Insurance Company Name: Policyholder's Name: Relationship to Patient: Employer of Policy Holder: Social Security #: Insurance ID #: Insurance Group #: Secondary Health Insurance Insurance Company Name: Policyholder's Name: Relationship to Patient: Employer of Policy Holder: Social Security #: Date of Birth: Date of Birth:	Phone:							
Insurance Company Name: Policyholder's Name: Relationship to Patient: Employer of Policy Holder: Social Security #: Insurance ID #: Insurance Group #: Secondary Health Insurance Insurance Company Name: Policyholder's Name: Relationship to Patient: Employer of Policy Holder: Social Security #: Date of Birth: Date of Birth:	Primary Health Insurance							
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:	Timaly neutra insurance							
Relationship to Patient: Employer of Policy Holder: Social Security #: Insurance ID #: Insurance Group #: Secondary Health Insurance Insurance Company Name: Policyholder's Name: Relationship to Patient: Employer of Policy Holder: Social Security #: Date of Birth: Date of Birth:	Insurance Company Name:							
Employer of Policy Holder: Social Security #: Insurance ID #: Insurance Group #: Secondary Health Insurance Insurance Company Name: Policyholder's Name: Relationship to Patient: Employer of Policy Holder: Social Security #: Date of Birth:	Policyholder's Name:							
Social Security #: 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:	Relationship to Patient:	Self	Spouse	Child	Other:			
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:	Employer of Policy Holder:							
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:	Social Security #:	Social Security #:						
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 Company Name: Policyholder's Name: Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth:	Insurance Group # :				_			
Policyholder's Name: Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth:	Secondary Health Insurance							
Policyholder's Name: Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth:	Insurance Company Name:							
Relationship to Patient: Self Spouse Child Other: Employer of Policy Holder: Social Security #: Date of Birth:								
Employer of Policy Holder: Social Security #: Date of Birth:		Self	Spouse	Child	Other:			
Insurance ID # ·	Employer of Policy Holder:							
Insurance ID #:	Social Security #:	Social Security #: Date of I						
	Insurance ID # :				<u> </u>			
Insurance Group # :	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:				