Neuro Focus Center, LLC

Patient Registration

Name: _____ Date of Birth ___ / ___ /____

Address: _____ Sex ☐ M ☐ F Age: _____

City:_____ State: _____ Zip:_____ SSN:_____-_____-_____

Home Phone _____ Cell Phone _____ Work Phone _____

Do we have you permission to leave messages on your voicemail at home or work? ____YES____NO

Marital Status: ☐S ☐M ☐D ☐W

Spouse's name: _____ Date of Birth ___ / ___ /____

Do we have permission to speak with your spouse/partner? ____YES ____NO

Please list anyone else, by name that we may speak with: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Primary Care Doctor:_____ Phone: _____

Referring Source _____ Phone: _____

Primary Pharmacy: _____ Phone: _____

Emergency Contact: _____ **Phone:**_____ **Relationship:** _____

Primary Insurance Company _____

Identification No: _____ Group No: _____ Effective Date _____/ _____ / ____

Policy Holder: _____ Social Security No: _____ Date of Birth _____ / _____ / ____

Relationship to Patient: _____ Employer : _____

Secondary Insurance Company _____

Identification No: _____ Group No: _____ Effective Date _____/ _____ / ____

Policy Holder: _____ Social Security No: _____ Date of Birth _____ / _____ / ____

Relationship to Patient: _____ Employer: _____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

_____ _____

Signature Date