Neuroscience & Spine Center of the Carolinas, L.L.P.

PATIENT REGISTRATION SHEET

Social Security # Title (Mr., Mrs., Ms.) Last Name First Name MI

Street Address City State Zip Code

Home Phone Date of Birth Sex (M/F)

Marital Status: Single(S) Married(M) Divorced(D) Widowed(W) Separated(X) Race: Black (B) White (W) Hispanic (H) Other (O) _____

Employment: Full(F) Part-Time(P) Retired(R) None(N)

Occupation Employer Work Phone Ext.

Student: Full(F) Part-Time(P) None(N) Name of School _____

Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance Insured's Name

Patient's Relationship to Insured: Self(SE) Spouse(SP) Child(CH) Other(O)

Insured's Information (if other than patient)

Social Security # Title (Mr., Mrs., Ms.) Last Name First Name MI

Street Address City State Zip Code

Home Phone Date of Birth Sex (M/F)

Employer Work Phone Ext.

IF YOU HAVE SECONDARY INSURANCE PLEASE CHECK BOX AND COMPLETE BACK OF FORM ☐

EMERGENCY CONTACTS

1.

Name Relationship to patient Address

Home Phone Work Phone

2.

Name Relationship to patient Address

Home Phone Work Phone

AUTHORIZATION/FINANCIAL INFORMATION

1. I hereby authorize the release of medical information to my insurance carriers concerning my medical condition and treatment.

2. I assign to Neuroscience & Spine Center of the Carolinas all payments from my insurance carrier for medical services rendered to myself or my dependents.

3. I fully understand that I am financially responsible for any co-pays, deductibles, co-insurance, or non-covered services as determined by my insurance carrier.

PAYMENT WILL BE COLLECTED AT THE TIME SERVICES ARE RENDERED

Signature Date