

**Mecklenburg Neurological Associates
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 Neurological or the insurance company to release any information required to process my claims.

Signature/Guardian Signature

Date