Metropolitan Neurosurgery, PA
Patient Registration Form

Patient Name _____ Birthdate _____
Last First MI

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Social Security # _____-_____-_____

Referred by _____ Primary Doctor _____

Race: White Asian Black or African American Hispanic Other _____

Marital Status: S M D W Separated___ Spouse Name _____ Preferred Language _____

Emergency Contact _____ Relationship _____ Phone # _____

Responsible Party
(If Other Than Above)

Name _____ Relationship _____
Last First MI

Birthdate _____ Social Security # _____ Employer _____ Work Phone _____

Home Address _____ Home Phone _____
Street City State Zip

Insurance Information

A copy of your insurance card will be taken at the time of your appointment.

Primary:
Health Auto Work Comp Liability (circle one)
Insurance Company Name _____
Address _____
Adjuster _____
Phone # _____ Date of Injury _____
Policy Holder _____
Claim or ID # _____
Group # _____

Secondary
Health Auto Work Comp Liability (circle one)
Insurance Company Name _____
Address _____
Phone # _____
Policy Holder _____
ID # _____ Group # _____

Attorney Information

Attorney Firm _____ Attorney Name _____
Address _____ Phone # _____

Assignment/Release of Information Authorization

I, the undersigned, hereby authorize payment of medical/surgical benefits directly to Metropolitan Neurosurgery, P.A. I authorize the release of my records to my insurance if required for claims submissions. I realize that all medical/surgical charges and accrued interest incurred by me, or my dependents, for services rendered at Metropolitan Neurosurgery, P.A. are my financial responsibility. If circumstances require the use of a third party collection agency, I understand that I will be responsible for payment of collections costs and/or attorney fees, if necessary. A photo copy of this original may be used in lieu of the original.

Signature _____ Relationship to Patient _____ Date _____