# NEUROLOGY AND SLEEP MEDICINE, P.C.

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## INSURANCE REGISTRATION FORM

NAME: ______________________________________________ DOB: ____________

HOME ADDRESS: __________________________________________________________

________________________________________________________________________

HOME PHONE: ____________________ ALTERNATE PHONE: ____________________

SOCIAL SECURITY: __________________ MARITAL STATUS: ____________________

EMPLOYER'S NAME: ______________________ WORK NUMBER: ________________

EMPLOYER'S ADDRESS: ____________________________________________________

PRIMARY DOCTOR: __________________ REFERRING DOCTOR: __________________

IF PATIENT IS UNDER 18:

MOTHER'S NAME: ____________________ DAYTIME PHONE: ____________________

FATHER'S NAME: ____________________ DAYTIME PHONE: ____________________

ADDRESS IF DIFFERENT FROM CHILD: ________________________________________

________________________________________________________________________

PRIMARY INSURANCE CO: __________________________________________________

GROUP #: ____________________ ID #:______________________

SUBSCRIBER/PT RELATION: __________________ EFFECTIVE DATE: ____________

SUBSCRIBER DOB: ____________________ SUBSCRIBER SS#: ____________

IS THIS ACCIDENT OR WORK RELATED? _______ DATE OF INJURY: ____________

SECONDARY INSURANCE CO: ________________________________________________

GROUP #: ____________________ ID #: ______________________

SUBSCRIBER/PT RELATION:__________________EFFECTIVE DATE: ____________

I, THE UNDERSIGNED PROMISED TO PAY FOR ALL TREATMENT AT THE TIME OF TREATMENT, UNLESS AGREED IN WRITING OTHERWISE. IF COLLECTION BECOMES NECESSARY, I AGREE TO PAY COURT COSTS, ALL OTHER COSTS OF COLLECTION AND THIRTY-THREE AND ONE-THIRD PERCENT (33 1/3%) ATTORNEY'S FEES. I AGREE TO PAY INTEREST AT THE RATE OF 1.5% PER MONTH ON ALL UNPAID BALANCES DUE AFTER 30 DAYS. I WAVE ALL MY HOMESTEAD DEED EXEMPTION RIGHTS. I AGREE THAT IF I HAVE APPLICABLE INSURANCE COVERAGE, THAT I REMAIN PRIMARILY LIABLE FOR THE TOTAL AMOUNT DUE AND THAT ALL INSURANCE BILLING IS A GRATUITY ONLY, UNLESS A MEDICARE CARE.

______________________________**(SEAL)** **DATE:** ____________
**PATIENT/GUARDIAN SIGNATURE**

______________________________**(SEAL)**
**PRINTED SIGNATURE**