South Florida Neurosurgery
REGISTRATION FORM

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Birth date:	Age:	Sex: ◯ M ◯ F	Social Security no.: [SS#]		

Address:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Referring Doctor: Preferred Pharmacy:

Is this visit for a second opinion?

Do you have a legal case pending?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?		Is this patient covered by insurance?	
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Co-payment: $	Policy no.:	Group no.:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize South Florida Neurosurgery or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date