Patient Registration Form
Suburban Neurologists, S.C.

Please complete this form and bring it with you to your appointment along with your insurance card, photo I.D., your referral, and a current medication list, including over the counter medicines or vitamins.

PATIENT

Male ☐ / ☐Female (please select)

Name: _____Birth date: _____
Last First Middle

Address: _____
Street City State Zip

Home phone: _____Work phone: _____Cell Phone: _____

Employer: _____ Social Security #: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

Insurance Information	Responsible Party
Primary	Secondary
Insurance Company: _____	**Insurance Company: _____**
Policyholder Name: _____	**Policyholder Name: _____**
Policyholder D.O.B.: _____	**Policyholder D.O.B.: _____**
Relationship: _____	**Relationship: _____**
I.D. / Policy #: _____	**I.D. / Policy #: _____**
Group #: _____	**Group #: _____**

INSURANCE ASSIGNMENT AND AUTHORIZATION

On order to submit a claim for payment for services covered under your policy, we must have your authorization to release medical information to your insurance carrier. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits payable to the doctor or group indicated on the claim. I understand that I am financially responsible for any balance not covered by the insurance carrier. A copy of this signature is as valid as the original.

Signature: _____Date: _____