

SALEM NEUROLOGICAL CENTER, PA
PATIENT REGISTRATION FORM

Today's Date: _____

Patient Information: (Please use full legal name, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ - _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status : _____ Drivers Lic # _____

Employer Name and Address: _____

_____ Work Phone # (_____) _____ - _____

E-mail Address: _____ Cell Phone # (_____) _____ - _____

Emergency Contact Name: _____ **Emerg Phone #:** (_____) _____ - _____

Please tell us how you heard about us: _____ Referred by: _____

Name of Primary Care Physician: _____

Guarantor Information: (List person or insured name responsible for bill – use full legal name, no nicknames)

Relationship of Guarantor to Patient: Self: _____ Spouse: _____ Parent: _____ Other: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____ - _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: Female _____ Male _____

Employer Name and Address: _____

_____ Work Phone #: (_____) _____ - _____

Insurance Information: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS.

PRIMARY INSURANCE:

Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____

Policy/ID #: _____ Group #: _____ Eff Date: _____

SECONDARY INSURANCE:

Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Date of Birth: _____

Policy/ID #: _____ Group #: _____ Eff Date: _____