Neurology
Brown Health Medical Group
BROWNHealth
UNIVERSITY

**OFFICE USE ONLY PT#** _____
**MD#** _____

# Patient Registration Form

**PATIENT INFORMATION** Is this visit related to a work injury? Yes No

Last Name _____ First Name _____ Middle _____ Age _____

Address _____ City/State _____ Zip _____

Home Phone (  ) _____ Cell/other phone (  ) _____ Email address _____

Date of Birth ___/___/___ Marital Status M S W D X Sex M F SS#XXX-XX- _____
(last 4 digits only)

Race: _____ (please pick one from below) Primary Language: _____
American Indian, Asian, Other Pacific, Black/African Amer. White, Hispanic, Other

Emergency Contact _____ Relationship _____ Phone (  ) _____

**FINANCIAL RESPONSIBILITY**

Last Name _____ First Name _____ Middle _____ Age _____

Address _____ City/State _____ Zip _____

Home Phone (  ) _____ Cell/other phone (  ) _____ Email address _____

Date of Birth ___/___/___ Marital Status M S W D Sex M F SS# XXX-XX- _____
(last 4 digits only)

Employer Name _____ Work Phone (  ) _____

**PATIENT EMPLOYER**

Name _____ Phone (  ) _____

Patient's occupation _____ Start date _____ Present status _____

**PRIMARY INSURANCE** Name _____ Policy # _____

Policyholder's Name _____ Relationship to Patient _____ Date of Birth _____

Policyholder's Employer _____ State _____ Phone (  ) _____

**SECOND INSURANCE** Name _____ Policy # _____

Policyholder's Name _____ Relationship to Patient _____ Date of Birth _____

Policyholder's Employer _____ State _____ Phone (  ) _____

**REFERRING PHYSICIAN** Name _____ Phone (  ) _____

**PRIMARY PHYSICIAN** Name _____ Phone (  ) _____

**NAME OF PHARMACY** **Name:** _____ **Address:** _____

**CONSENT**

I, _____, consent to treatment necessary for the care of the above patient. I authorize the release of all medical information/records to referring/family physicians and to my insurance company, if applicable. I allow facsimile (fax) transmittal of my medical records if necessary.

SIGNATURE _____ PRINT NAME _____ DATE _____