NEUROLOGY GROUP OF BERGEN COUNTY, P.A.

PATIENT REGISTRATION FORM
PLEASE COMPLETE ALL AREAS

Patient Name:

Street, Apartment:

City, State, Zip:

Home Phone #: Work #:

Cell Phone: E-mail:

Birth Date: Sex:

Social Security #: Marital Status:

Primary Care Physician: Phone #:

Primary Care Physician Address:

Referring Physician: Phone #:

Referring Physician Address:

Emergency Contact:

Relationship To Patient: Phone #:

INSURANCE INFORMATION-MUST BE COMPLETED

Primary Insurance:

ID #: Group #:

Name Of Insured:

Relationship To Patient:

Insured's DOB:

Insured's Employer: Phone #:

SECONDARY INSURANCE

Insurance Name:

ID #: Group #:

Name Of Insured: DOB:

Relationship To Patient:

Employer: Phone #:

(Continue on back)

THE FOLLOWING INFORMATION IS REQUESTED BY THE FEDERAL GOVERNMENT

Patient's Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Refuse to answer
Patient's Race:	☐ American Indian or Alaska Native	☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander
☐ White	☐ Asian	☐ Declined to Specify	☐ Other
Patient's Preferred Language:	☐ English	☐ Spanish	☐ Russian
	☐ Other (Please Specify)		

PHARMACY INFORMATION

Pharmacy Name: Town: State:

Pharmacy Telephone Number:

Parents / Guardians Information for children under 18:

Mother's Name:	Father's Name:
Home Address:	Home Address:
Social Security #:	Social Security #:
Home #:	Home #:
Work #:	Work #:

If a balance exists after submitting to insurance, Send Bill to: ☐ Mother ☐ Father

PLEASE NOTE: BOTH PARENTS / GUARDIANS ARE RESPONSIBLE FOR THEIR CHILDREN'S MEDICAL BILLS.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. IF THE NEUROLOGY GROUP OF BERGEN COUNTY P.A. PARTICIPATES WITH MY INSURANCE I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE NEUROLOGY GROUP PHYSICIAN. I AUTHORIZE THE NEUROLOGY GROUP OF BERGEN COUNTY, P.A. TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY INSURANCE CLAIMS.
REGARDLESS OF MY INSURANCE STATUS, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICE THAT I RECEIVE.

Signature Of Patient Or Responsible Party:

Relationship To Patient: Date: