Community
NEUROLOGIC
Center

PATIENT REGISTRATION

2401 Kaneville Rd., Suite 8, Geneva, IL 60134, Tel. 630-208-7735, Fax 630-208-6956

I. Patient Information (please, print clearly):

LAST NAME			EMPLOYMENT	EMPLOYER	
FIRST NAME	M. I.			STREET	
STREET				CITY	STATE / ZIP
CITY	STATE / ZIP			PHONE	FAX
HOME PHONE	CELL PHONE			CONTACT PERSON	
E-MAIL	DATE OF BIRTH			EMPLOYMENT (circle one) FULL TIME PART TIME RETIRED STUDENT	
MARITAL STATUS (circle one) M W D S	SEX M F	SSN		REASON for VISIT	
REFERRING DOCTOR				PHONE	
EMERGENCY CONTACT	RELATIONS			PHONE	

II. Responsible Party (please, print clearly): (Person responsible for payment of the patient's account if different than above.)

PRIMARY INSURED			SECONDARY INSURED		
NAME OF CARRIER			NAME OF CARRIER		
DATE OF BIRTH	S.S.N.		DATE OF BIRTH	S.S.N.	
RELATIONSHIP TO PATIENT (circle one) SELF SPOUSE PARENT OTHER	SEX (circle one) M F		RELATIONSHIP TO PATIENT (circle one) SELF SPOUSE PARENT OTHER	SEX (circle one) M F	
EMPLOYER			EMPLOYER		
STREET	CITY		STREET	CITY	
STATE / ZIP	PHONE		STATE / ZIP	PHONE	

OFFICE USE ONLY

IN NETWORK | OUT of NETWORK (circle one)

IDM CODE

FDM CODE

Primary Policy	Number	Effective Date	End Date	
Co-Insurance	Professional Visit In Plan Network	Professional Visit Out of Plan Network		
Co-Payment	Professional Visit In Plan Network	Professional Visit Out of Plan Network		
Deductible	Individual In plan Network	Family In plan Network	Individual Out of Plan Network	Family Out of Plan Network

III. Insurance Authorization

I understand that payment is expected at time of service unless other arrangements have been made in advance. I certify that the information I have reported with regard to my insurance is correct. I hereby authorize ***Community Neurologic Center*** to apply for benefits on my behalf for services and request that payment from my insurance company be made directly ***Community Neurologic Center***. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I certify that the above information is correct.

Signature_____ Date_____