Community NEUROLOGIC Center

WC-AA PATIENT REGISTRATION

SCHEDULED DATE of SERVICE:_____

I. Patient Information (please, print clearly):

PATIENT'S NAME			EMPLOYER		
S.S.N.	HOME PHONE		ADDRESS	PHONE	
ADDRESS			CITY	STATE	ZIP
CITY	STATE	ZIP	EMPLOYMENT (circle one) FULL TIME PART TIME RETIRED		
DATE OF BIRTH			REFERRING DOCTOR	PHONE	
MARITAL STATUS (circle one) M W D S		SEX (circle one) M F	EMERGENCY CONTAC T	RELATIONS	PHONE

WC Workers Compensation Information (please, print clearly):

Date of Injury _____ Workers Comp. Claim No. _____

Workers Comp. Carrier Name _____

Workers Comp. Carrier Address: _____
Street, City, State Zip

Workers Comp. Carrier Adjuster Name: _____

Phone: (_____)_____ FAX: (_____) _____ Account / Group: _____

Area of Complaint (Arm, Leg, Back, etc.) _____

_____

PRIMARY INSURED
NAME OF CARRIER
POLICY OWNER'S DATE OF BIRTH
SSN
RELATIONSHIP TO PATIENT (circle one) SELF SPOUSE PARENT OTHER
SEX (circle one) M F
POLICY OWNER'S EMPLOYER
PHONE
ADDRESS
CITY
STATE / ZIP

AA Auto Accident (please, print clearly):

Accident Date _____ Claim No. _____

Insured's Name (Responsible Party) _____
Last name First name M.I.

Insurance Company _____

Insurance Company Address _____
Street, City, State Zip

Attorney:

Name _____

Address: _____
Street, City, State Zip

Phone: (_____) _____ FAX: (_____) _____

Insurance Authorization

All Patients: 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_____

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