South Coast Neurology, Inc.

Patient Registration Form

Please fill out ALL Fields If not applicable, write N/A

LAST NAME	**FIRST NAME**	**INITIAL**
ADDRESS	**CITY/STATE/ZIP**	
HOME PHONE #	**WORK PHONE #**	
EMAIL ADDRESS	**CELL PHONE #**	
MESSAGES ABOUT ACCOUNT BALANCES AND FUTURE APPOINTMENTS WILL BE LEFT ON THE CONTACT INFORMATION PROVIDED ABOVE		
DATE OF BIRTH	**MALE[ ] FEMALE[ ]**	**MARITAL STATUS**
SOCIAL SECURITY NUMBER	**REFERRING DOCTOR**	
EMPLOYMENT (Check One) FULL TIME [ ]	**PART TIME [ ]**	**STUDENT [ ]**
EMPLOYER	**PHONE**	
ADDRESS	**CITY/STATE/ZIP**	
INSURANCE INFORMATION:		
PRIMARY INSURANCE NAME		
NAME OF POLICY HOLDER	**RELATIONSHIP OF PATIENT TO THE INSURED**	
DATE OF BIRTH	**SOCIAL SECURITY NUMBER**	
INS ADDRESS	**CITY, STATE, ZIP**	
INSURED'S ID #	**GROUP # EFFECTIVE DATES**	
SECONDARY INSURANCE NAME		
NAME OF POLICY HOLDER	**RELATIONSHIP OF PATIENT TO THE INSURED**	
DATE OF BIRTH	**SOCIAL SECURITY NUMBER**	
INS ADDRESS	**CITY, STATE, ZIP**	
INSURED'S ID #	**GROUP # EFFECTIVE DATES**	
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?		**PHONE #**
WORKERS' COMPENSATION/PERSONAL INJURY INFORMATION		
ATTORNEY NAME	**ATTORNEY PHONE**	
WERE YOU HURT AT WORK?	**Y N DATE OF INJURY**	
HAVE YOU FILED A CLAIM	**Y N**	
WORKERS' COMPENSATION CLAIM #	**ADJUSTERS NAME**	
ADJUSTERS PHONE	**ADJUSTERS ADDRESS**	**CITY, STATE, ZIP**

Our staff is trained to inform you of the financial policies of this office.

- **Payment is due at the time of service. If payment is not paid at time of service, a $10 billing fee will be applied**
- **Appointments for regular care that are not canceled at least 48 hours before the scheduled appointment during hours of operations are subject to a $40 "NO SHOW FEE".**
- **We accept payment in the form of cash, check and credit card (*).**
- **I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits or non-payment.**
- **In the event it is necessary to refer your account to an attorney for collections, you will be responsible for all charges accrued; i.e. attorney's fees, court costs, expenses, etc.**

**** Check Writing Policy: No check will be honored without driver's license. All returned checks are subjected to a return check fee of $40***

*** Declined Card: Any card that is declined is subject to a $40.00 fee, regardless of the balance as well as late fees that apply to an overdue balance.**

I am aware that obtaining test results may require a face-to-face consult with a licensed medical professional. Some test results cannot be given over the phone, email and/or via facsimile. These regulations are in compliance with appropriate medical care guidelines and other government agencies within the State of California. _____Initials

SIGNATURE OF PATIENT OR LEGAL GUARDIAN (SEAL) **DATE**