### Chattanooga Neurology Associates

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ACCOUNT # Click here to enter text. DATE Click here to enter text. | | | | | | | | | | **REFFERRED BY DR** Click here to enter text. | | | | | | | | |
| **PATIENT'S PRIMARY CARE PHYSICIAN:** Click here to enter text. | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | |
| PATIENT'S FIRST NAME:  Click here to enter text. | | | MIDDLE  Click here to enter text. | | | | | | | LAST:  Click here to enter text. | | |  | | BIRTHDATE    Click here to enter text. / / | | | AGE  Click here to enter text. |
| STREET ADDRESS Click here to enter text. CITY/State | | | | | | | | | | | | | ZIP CODE  Click here to enter text. | | | |
| SOCIAL SECURITY#  Click here to enter text. | HOME PHONE #    Click here to enter text. | | | | | MOBILE PHONE#  Click here to enter text. | | | | | WORK OR BUSINESS PHONE#  Click here to enter text. | | | | MARITAL **STATUS M/S/D** | | SEX  Click here to enter text. | |
| EMPLOYER'S NAME AND ADDRESS  Click here to enter text. | | | | | | | | ❑01 AFRICAN AMERICAN ❑08 NATIVE AMERICAN  ❑02 ASIAN ❑11 OTHER \_\_\_\_\_\_\_\_\_\_\_  ❑03 CAUCASIAN  ❑06 HISPANIC | | | | | | | | | | |
| PATIENT OR CONTACT  **EMAIL ADDRESS**  Click here to enter text. | | | | | | | | | | PRIMARY LANGUAGE  Click here to enter text. | | | | | | | | |
| SPOUSE, PARENT, NEXT OF KIN Click here to enter text. | | | | | | | | | PHONE # Click here to enter text. | | | | | | | | | |
| **PHARMACY OF CHOICE** Click here to enter text.  PHARMACY PHONE # | | | | | | | | | PHARMACY STREET/CITY  Click here to enter text. | | | | | | | | | |
| HAVE YOU BEEN TREATED BY A CHATTANOOGA NEUROLOGY ASSOCIATES PHYSICIAN PREVIOUSLY? YES NO | | | | | | | DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE? YES NO  DO YOU HAVE A LIVING WILL? YES N O | | | | | | | | | | | |
| **NATURE OF ILLNESS OR INJURY: DATE OF FIRST SYMPTOM OR DATE OF INJURY:**  Click here to enter text.Click here to enter text. | | | | | | | | | | | | | | | | | | |
| **PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)** | | | | | | | | | | | | | | | | | | |
| FIRST NAME  Click here to enter text. | | | | MIDDLE NAME  Click here to enter text. | | | | | LAST  Click here to enter text. | | | | | | RELATIONSHIP TO PATIENT  Click here to enter text. | | | |
| ADDRESS  Click here to enter text. | | | | | | | | | | CITY  Click here to enter text. | | | STATE  Click here to enter text. | | ZIP CODE  Click here to enter text. | | | |
| SOCIAL SECURITY # | | HOME PHONE # | | | | | | | | MOBILE PHONE # | | | | WORK PHONE# | | | | |
| **EMERGENCY CONTACT (NOT WITHIN THE SAME HOUSEHOLD**) **RELATIONSHIP TO PATIENT**  **EMERGENCY PHONE NUMBER**  **NAME** Click here to enter text.Click here to enter text.Click here to enter text. | | | | | | | | | | | | | | | | | | |
| PRIMARY INSURANCE \* INSURANCE INFORMATION \* SECONDARY INSURANCE | | | | | | | | | | | | | | | | | | |
| **PRIMARY INSURANCE** | | | | | | | | | | SECONDARY INSURANCE | | | | | | | | |
| INSURANCE NAME  Click here to enter text. | | | | | EFFECTIVE DATE  Click here to enter text. | | | | | INSURANCE NAME  Click here to enter text. | | | | | | EFFECTIVE DATE  Click here to enter text. | | |
| CLAIMS ADDRESS  Click here to enter text. | | | | | | | | | | CLAIMS ADDRESS    Click here to enter text. | | | | | | | | |
| SUBSCRIBER ID NUMBER  Click here to enter text. | | | GROUP NUMBER  Click here to enter text. | | | | | | | SUBSCRIBER ID NUMBER  Click here to enter text. | | | | GROUP NUMBER  Click here to enter text. | | | | |
| SUBSCRIBER NAME AND ADDRESS  Click here to enter text. | | | | | | | | | | SUBSCRIBER NAME AND ADDRESS  Click here to enter text. | | | | | | | | |
| SUBSCRIBER BIRTHDATE Click here to enter text. | | | | | | | | | | SUBSCRIBER BIRTHDATE Click here to enter text. | | | | | | | | |
| SUBSCRIBER SS#  Click here to enter text. | | | RELATION TO PATIENT  Click here to enter text. | | | | | | | SUBSCRIBER SS#  Click here to enter text. | | | | RELATION TO PATIENT  Click here to enter text. | | | | |
| EMPLOYER NAME, ADDRESS AND PHONE NUMBER    Click here to enter text. | | | | | | | | | | EMPLOYER NAME, ADDRESS AND PHONE NUMBER    Click here to enter text. | | | | | | | | |
| **IS THIS WORKMAN'S COMPENSATION? YES NO VERIFIED**: | | | | | | | | | | | | | | | | | | |
| WORKMAN'S COMP CARRIER    Click here to enter text. | | | | | | | | | | PHONE#    Click here to enter text. | | ADJUSTOR    Click here to enter text. | | | CLAIM# | | | |