### 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 NODO 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 NAMEClick here to enter text.  | EFFECTIVE DATEClick 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#   |