Patient's Preferred Pharmacy **Pharmacy Phone #**

ATHENS NEUROLOGICAL ASSOCIATES, P.C.

Patient Registration Form

Dr.	Account #	Chart#

PATIENT INFORMATION

Last Name	First Name	Middle
Street Address (Apt or Suite #)		
City / State / Zip Code		
Home Telephone #	Cell Phone #	Sex □Male □Female
E-Mail address	Marital Status □ Single □ Married □ Divorced □ Widowed	
Preferred Method of Communication: □E-Mail □Mail □Phone □Text □Patient Portal □Declined		
Pref Language □English □Spanish □Decline Answer	Ethnicity □Hispanic or Latino □Not Hispanic or Latino □Decline Answer	
Race □American Indian or Alaska Native □Asian □Black/African American □Nat Hawiian/Pacific Islander □White □Other Race □Decline Answer		
Date of Birth	Referring Doctor Name	
Social Security #	Address	
Employer	City / State / Zip Code	
Address (Suite #)	Phone #	
City / State / Zip Code	Emergency Contact	
Employer Phone #	Emergency #	
Occupation	Relationship	

RESPONSIBLE PARTY / BILLING INFORMATION

Last Name	First Name	Middle
Relationship	Social Security #	
Date of Birth	Employer Name	
Home Adress	Employer Address	
City / State / Zip Code	Phone #	ext
Pref Language □English □Spanish □Decline Answer	Ethnicity □Hispanic or Latino □Not Hispanic or Latino □Decline Answer	
Race □American Indian or Alaska Native □Asian □Black/African American □Nat Hawiian/Pacific Islander □White □Other Race □Decline Answer		

PRIMARY INSURANCE

Name of Company	Member ID #	Effective Date
Claims Mailing Address	Group #	
City / State / Zip Code	Policyholder Name	
Company Phone #	Policyholder SSN	DOB

SECONDARY INSURANCE

Name of Company	Member ID #	Effective Date
Claims Mailing Address	Group #	
City / State / Zip Code	Policyholder Name	
Company Phone #	Policyholder SSN	DOB

PATIENT AUTHORIZATION

I consent to treatment necessary for the care of the above named patient.
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I allow fax transmission of my medical records, if necessary.
I acknowledge full financial responsibility for services rendered by Athens Neurological Associates, P.C.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I agree to pay all attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that insurance payments be made directly to Athens Neurological Associates should they elect to receive such payment.

Date _____ Signature _____