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:	Email Address:	
Home Telephone #:	Cell Phone #:	
Sex: Male / Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
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 Address:	Employer Address:	
City / State / Zip Code:	Phone #:	Ext:

PRIMARY INSURANCE

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

SECONDARY INSURANCE

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