Neurology Center of San Antonio
PATIENT REGISTRATION FORM

Patient Information:
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Last Name | First Name | Middle Initial | SS#

Address | City | State | Zip Code

Date of Birth | Age | Sex | Driver License #

Home Phone | Work Phone | Cell Phone

Responsible Party Information:
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Last Name | First Name | Middle Initial | SS#

Address | City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Insurance Information: **Is this visit Workers Compensation related? ☐ Yes ☐ No**
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Primary Insurance Name and Address

Primary Policy I.D.# / Group # | Subscriber Name / Relationship | DOB | SS #

Secondary Insurance Name and Address

Secondary Policy I.D. # / Group # | Subscriber Name / Relationship | DOB | SS #

Emergency contact and person authorized to receive medical information:

Name: _____ Phone: _____ Relationship _____

Referring Doctor: _____ _____
First Name | Last Name

I authorize and consent to such diagnostic testing and medical treatment my physician considers necessary. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Patient or Legal Guardian Signature: _____ Date: _____