

PATIENT REGISTRATION FORM

Denver Neurological Clinic

(Print clearly & press firmly in black ink)

Today's Date _____

Patient Name _____
Last First MI Nickname

Date of Birth _____ SSN _____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____

Primary Phone () _____ May we leave a message? (circle) YES / NO

Secondary Phone () _____ May we leave a message? (circle) YES / NO _____

Work Phone () _____ OK to call work? (circle) YES / NO

Patient's Employer _____

Primary reason for today's visit _____

Primary Care Physician _____ Referring Physician _____
Last First Last First

Is this work-related? (circle) YES NO Related to an auto accident? (circle) YES NO *If YES on EITHER, please complete Auto/WC Form*

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient _____ Employer _____ Employer Phone () _____

Secondary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient _____ Employer _____ Employer Phone () _____

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) **Working-Aged** **ESRD** **Auto/Med/No Fault Liability** **Workers Comp** **Federal Black Lung** **Veterans Affairs** **Disability** **Other Liability**

If you do not have insurance, have you applied for government assistance? (circle) YES NO If yes, provide social worker's information.

Social Worker's Name _____ Phone () _____

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone() _____ Secondary Phone() _____

Custodial Parent's SSN _____ Date of Birth _____

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name _____ Relationship _____ Phone() _____
Last First

Name of person we may speak with other than yourself regarding your medical care? _____

Primary Phone() _____ Secondary Phone() _____ Relationship _____

AUTO & WORKERS' COMPENSATION

Denver Neurological Clinic

(Print clearly & press firmly in black ink)

Today's Date _____

Patient Name _____ Date of Birth _____
Last First MI Nickname

Date of Accident ____/____/____ Where Injury Occurred (State) _____

Type of Accident: (circle) AUTO / WORK-RELATED / OTHER _____

Chief Complaint _____

Auto Insurance Information

Insurance Name _____ Policy #/ID _____

Claim No. _____ Policy Holder's Name _____ Phone (____) _____

Adjuster/Representative Name _____

Workers' Compensation Information

Occupation _____

If employment related, responsible employer's name _____

Employer Address _____
Street Apt/Ste City State Zip

Employer Phone (____) _____ W/C Insurance _____ Claim Number _____

Explanation of how the injury/problem occurred _____

Anatomical Area of Injury _____ SIDE: RIGHT LEFT

Are you involved in competitive sports? (circle) YES NO TYPE _____

Occupational Activities _____

List all medications you are presently taking _____

List any drug allergies: _____

Patient Signature (or Parent/Guardian/Other Authorized Person if patient is a minor)

Today's Date

Today's Date _____

Patient Name _____
Last First MI

Date of Birth _____ SSN _____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated.

Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately.

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to Denver Neurological Clinic on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____ ***(Initial) I have read and agree to the above statement.***

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Denver Neurological Clinic to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ ***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____ ***(Initial) I have read and agree to the above statement.***

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

_____ ***(Initial) I have read and agree to the above statement.***

WORKERS' COMPENSATION: I will provide approval/authorization by the Workers' Compensation carrier at the initial visit. If the claim is deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney and/or the Workers' Compensation carrier will be provided to this office.

_____ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS: I understand and agree to pay a returned check charge of \$35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

_____ ***(Initial) I have read and agree to the above statement.***

PRIVACY POLICY: I have been made aware of the privacy policy of Denver Neurological Clinic and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

PRINT NAME _____

SIGNATURE _____ DATE _____

NEW PATIENT INTAKE FORM
(Please circle or fill in the blanks to all that apply)

NAME: _____

DATE: _____

PRIMARY REASON FOR VISIT: _____

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, & OVER-THE-COUNTER MEDICATIONS):

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

MEDICATION ALLERGIES (LATEX, CONTRAST DYE, & OTHER MEDICATIONS):

- 1.
- 2.

FAMILY MEDICAL PROBLEMS (SEIZURE, STROKE, HEART DISEASE, CLOTTING DISORDERS, CANCER, DIABETES, HYPERCHOLESTEROLEMIA, HEADACHES, & NEUROLOGICAL DISORDERS, ETC):

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

EMPLOYMENT (TYPE OF WORK): _____

MARTIAL STATUS (SINGLE/ MARRIED/ DIVORCED/ WIDOWED/ OTHER): _____

NUMBER OF CHILDREN: _____

TOBACCO USE: CURRENT PACKS PER DAY _____ **/ PAST YEARS OF SMOKING** _____

ALCOHOL USE: DRINKS PER WEEK _____

CAFFEINE USE: DRINKS PER DAY _____

SLEEP QUALITY: GOOD/ POOR _____ **NUMBER OF HOURS** _____

***If you are a woman, please note if you are pregnant, could be pregnant, or planning to be pregnant: YES/ NO**