PATIENT REGISTRATION FORM

Colorado Neurodiagnostics, PLLC

(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__________