Southern California Neurology Consultants

625 S. Fair Oaks Ave., Suite 325
Pasadena, CA 91105
Telephone: (626) 535-9344
Fax: (626) 535-9387

416 E. Colorado St., Suite A
Glendale, CA 91205
Telephone: (818) 265-2245
Fax: (888) 990-2775

Patient Registration

Referral Source: ______________________

PLEASE ANSWER ALL OF THE FOLLOWING CONFIDENTIAL QUESTIONS COMPLETELY.

Patient Information

Patient's Last Name ______ First Name ______ Initial ______

Home Address ______ City ______ State ______ Zip ______

DOB ______ Age ______ Birth Place ______ Race ______ Gender ? ☐ Male ☐ Female

Ethnicity? ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Patient Declined Social Security No. ______

Driver's License #/ID: ______ ***(Provide Copy of Card)*** Marital Status ______

E-mail ______ Consent to use? ☐ Yes ☐ No Preferred Language: ______

Home Phone ______ Work Phone ______ Ext. ______ Cell Phone ______

Is patient a student? ☐Yes ☐No If yes: ☐PT ☐FT Provide school name & address: ______

Emergency contact Name ? ______ Relationship ? ______ Phone ______

Responsible Person Information

☐ If Same as Patient, Please Skip This Section Relationship to Patient ? ______

Last Name ______ First Name ______ Initial ______

Home Address ______ City ______ State ______ Zip ______

DOB ______ Social Security No. ______ Gender ? ☐ Male ☐ Female

Home Phone ______ Cell ______

E-mail ______ Consent to use ? ☐ Yes ☐ No

Employer Information

Employer Name ______ Phone ______

Employer Address ______ City ______ State ______ Zip ______

Pharmacy Information

Pharmacy ______ Phone ______ Fax ______

Address ______ City ______ State ______ Zip ______

Primary Medical Insurance Information *- Please Complete OR Provide Copy of Current Insurance Card*

☐ If NO Medical Insurance, Please Skip Insurance Sections Employer Name ______

Insured Last Name ______ First Name ______ Initial ______

Relationship: ______ DOB ______ Social Security No. ______

Insurance Name ______ Phone ______

Insurance Address ______ City ______ State ______ Zip ______

Subscriber ID ______ Group Number ______

Secondary Medical Insurance Information *- Please Complete OR Provide Copy of Current Insurance Card*

☐ If NO Medical Secondary, Please Skip This Section Employer Name ______

Insured Last Name ______ First Name ______ Initial ______

Relationship: ______ DOB ______ Social Security No. ______

Insurance Name ______ Phone ______

Insurance Address ______ City ______ State ______ Zip ______

Subscriber ID ______ Group Number ______

AUTHORIZATION

I hereby authorize the practice to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the practice for any services rendered that are not paid for directly by me.

Responsible Person Signature ______ Date: ______

I acknowledge that I have received a copy of the "HIPAA - Notice of Privacy Practices".

Responsible Person Signature ______ Date: ______

© 2014 Southern California Neurology Consultants --- All Rights Reserved.