HUMBOLDT NEUROLOGICAL MEDICAL GROUP, INC. **PATIENT REGISTRATION**

Date_________________________ **What pharmacy do you use?** ________________________________

PATIENT'S NAME ____________________________________ Sex: M F Birth Date______________________Age_______

*Parent/Guardian (if under 18*______________________________________ *Parent/Guardian Birth Date:* _____________________

Street Address____ Mailing Address___________________________________

City____State____________________Zip______________________________

Home Phone ________________________Cell Phone ________________________ Social Security # ________________________

Message Ph: _________________Race_____________ Ethnicity: (*Hispanic*) **or** (*Non Hispanic or Latino*) Marital Status: M S D W

Patient's Employer ______________________ Occupation ______________________Driver's License # ______________________

Employer's Address____Work Phone__________________________

Please fill out your spouse's information (if applicable). This is important for both health and billing purposes. Thank you.

Spouse's Name____Social Security #__________________________________

Spouse's Date of Birth_______________ Employer___________________Occupation______________________________________

Is this a **work related injury**? Yes No If Yes, is a first report on file? Yes No Date of Injury_________________________

Worker's Comp Insurance Name____Claim #______________________________

Worker's Comp Address____Adjuster's Name_______________________

Is this an injury from a **motor vehicle accident**? Yes No If yes, Date of Injury____

Referring Physician _____________________________Your Primary Doctor/Family Physician ______________________________

Caregiver or Care Home Name *(if applicable)*: ______________________________________ Phone: _________________________

INSURANCE INFORMATION Circle all methods of payment that apply.

None Worker's Comp Insurance (see above) Medicare Medi-Cal/CMSP Private Ins Other/Attorney

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name____	Name____
Policy____	Policy____
Group#____	Group#____
Address____	Address____
Name of Insured______________________________________	Name of Insured______________________________________

ASSIGNMENT AND MEDICAL RECORDS RELEASE: All patients, please read and sign below.

I hereby assign directly to Humboldt Neurological Medical Group, Inc. (HNMG) all medical benefits, if any, otherwise payable to me for services rendered by them. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize HNMG to release all medical and billing information necessary to secure the payment of benefits to my insurer(s) and to my other treating physician(s). I authorize the use of this signature on all my insurance forms.

Signature of Patient/Insured____Date_________________________

MEDICARE AUTHORIZATION: Patients with Medicare insurance, please read and sign below.

I request that payment of authorized Medicare benefits be made on my behalf to Humboldt Neurological Medical Group, Inc.(HNMG) for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to HNMG and authorizes release of medical information necessary to pay for my services. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on any other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, HNMG agrees to accept the charge determination of the Medicare carrier as the full charge, and I will be responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient/Insured____Date_________________________

Revised 11-09-12