CONNECTICUT NEUROSURGICAL SPECIALISTS, P.C.

REGISTRATION FORM

NAME: _____ DOB: _____ SEX: _____

ADDRESS: _____

PHONE: (H)_____ (W) _____ (C) _____

May we leave a message? YES NO

SOCIAL SECURITY #: _____ MARITAL STATUS: S M W D

EMERGENCY CONTACT PERSON: _____
RELATIONSHIP: _____ PHONE #: _____

PRIMARY INSURANCE: _____
SUBSCRIBER'S NAME: _____
SUBSCRIBER'S DOB: _____ SS #: _____
SUBSCRIBER'S EMPLOYER: _____
ID #: _____ GROUP #: _____
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT GUARDIAN

SECONDARY INSURANCE: _____
SUBSCRIBER'S NAME: _____
SUBSCRIBER'S DOB: _____ SS #: _____
SUBSCRIBER'S EMPLOYER: _____
ID #: _____ GROUP #: _____
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT GUARDIAN

IF THIS VISIT IS RELATED TO A WORK INJURY PLEASE COMPLETE:

DATE OF INJURY: _____ BODY PART: _____
INSURANCE CARRIER: _____
ADDRESS: _____
_____
CLAIM #: _____
CONTACT PERSON: _____ PHONE #: _____

PAYMENT & COPAYMENTS, IF APPLICABLE, ARE REQUIRED AT TIME OF OFFICE APPOINTMENT. WE DO NOT ACCEPT MEDICARE ASSIGNMENT.

I authorize this office to release any information to process an insurance claim. I authorize my insurance benefits to be paid directly to CNS for all services submitted to my insurance company by the office. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and cost of collection in the event of default. I hereby authorize CNS to furnish from their records any information requested by any doctors who are connected to my care.

SIGNATURE: _____ DATE: _____