# Northwest NeuroSpecialists Patient Registration

(ADULT)

**Date of Birth:**____/____/_____ **Date of Visit:**_____/_____/_____

☐ **New Patient** **PLEASE PRINT**

| Patient First Name | Patient Middle Name | Patient Last Name |
|---|---|---|
| | | |

| | | | |
|---|---|---|---|
| **Sex:** ☐ Male ☐ Female ☐ Intersex ☐ MtF Female ☐ FtM Male | | **Social Security #:** | |
| **Street Address** (Arizona) **Apt/Space** | **City** | **State** | **Zip Code** |
| | | | |
| **Street Address** (Out of State) **Apt/Space** | **City** | **State** | **Zip Code** |
| | | | |

| Home Phone  Preferred Number | Cell Phone  Preferred Number | Other Phone  Preferred Number |
|---|---|---|
| | | |
| **Marital Status:** | ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner ☐ Other | |

| Primary Insurance Name | Group ID# | Member ID# |
|---|---|---|
| | | |

| Medical Claims Address | City-State-Zip | Phone |
|---|---|---|
| | | |

| | | | |
|---|---|---|---|
| **Is patient the policy holder?** | ☐ Yes ☐ No | **If no, patient's relationship to policyholder:** | ☐ Spouse ☐ Domestic Partner ☐ Other |

| Policyholder's Name (if different from patient) | Policyholder's Date of Birth |
|---|---|
| | |

| Secondary Insurance Name | Group ID# | Member ID# |
|---|---|---|
| | | |

| Medical Claims Address | City-State-Zip | Phone |
|---|---|---|
| | | |

| | | | |
|---|---|---|---|
| **Is patient the policy holder?** | ☐ Yes ☐ No | **If no, patient's relationship to policyholder:** | ☐ Spouse ☐ Domestic Partner ☐ Other |

| Policyholder's Name (if different from patient) | Policyholder's Date of Birth |
|---|---|
| | |

# Northwest NeuroSpecialsts Patient Registration

| **Person Legally Responsible for Payment** (if not the patient) | ☐ Parent ☐ Other_____ | |
|---|---|---|
| **Name of Responsible Party** | **Social Security #** | **Date Of Birth** |
| | | |
| **Address** | **City-State-Zip** | **Phone** |
| | | |

| **Emergency Contact Information** | | |
|---|---|---|
| **Contact is:** ☐ Spouse ☐ Parent ☐ Guardian ☐ Friend ☐ Domestic Partner ☐ Other | | |
| **First Name** | **Middle Name** | **Last Name** |
| | | |
| **Home Phone** | **Cell Phone** | **Other Phone** |
| | | |

| **Name of Patient's Primary Care Provider:** | |
|---|---|

**Who Referred you to Northwest NeuroSpecialists**

☐ Primary Care Provider ☐ Advertising ☐ Internet ☐ Family or Friend ☐ Health Fair
☐ Other Provider(Name):_____ ☐ Hospital or Urgent Care ☐ Insurance

| **Advanced Directives** | | | |
|---|---|---|---|
| **Patient Name:** | | **Date of Birth:** | |
| **Does the patient have a Living Will?** | ☐ **Yes** ☐ **No** If yes, where is it kept: | | |
| **Does the patient have a Healthcare Power of Attorney?** | | ☐ **Yes** ☐ **No** | |
| **If yes, Name & Contact Phone Number:** | | | |
| ☐ I would like a Living Will and/or Healthcare Power of Attorney Form | | | |

**May we call you after your visit to find out if our service was satisfactory?**

☐ Yes, my home phone ☐ Yes, my cell phone ☐ Yes, my other phone ☐ No, do not call

I certify the above information is true and accurate. I acknowledge that upon my request, I may receive a hard copy of the Notice of Privacy Practices.

_____ _____

**Patient's Signature or Legal Representative** **Date**