SUNSHINE NEUROLOGY PA
REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status: Single Married Divorced Widow Separated

Is this your legal name? Yes ◉ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: M F

Address:

Social Security no.:	Home phone no.: Is it ok for us to leave a message: Yes ☐ no ☐	Cell phone no.: Is it ok for us to leave a message: Yes ☐ no ☐
Occupation:	Employer: Employer phone no.:	Email address:

How did you hear about us? Other family members seen here:

Please circle which apply: Caucasian African American Asian American Indian Hispanic other

Ethnicity: Hispanic or Latin Non-Hispanic or Latin Refuse to response

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	Yes No	Is this patient covered by insurance?	Yes No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other:

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sunshine Neurology PA or insurance company to release any information required to process my claims.

Patient/Guardian signature Date