NEUROPSYCHOLOGY ASSOCIATES, P.C.
PATIENT REGISTRATION
Name of person filling out this form (if not patient)

_____

PATIENT INFORMATION

Name _____

Sex___ Age _____ Birth Date _____ / _____ /_____

Date of appointment_____

Who referred you to our office? _____

Who is responsible for payment for services rendered? _____

Patient Contact Information

Patient Mailing Address_____
Street City State Zip

Phone Number Home: _____

Work: _____

Cell: _____

Email: _____

Please circle preferred method of contact

Do we have your permission to leave a voicemail message for you at your home? □ Yes □ No

Do we have your permission to leave a message with a family member? □ Yes □ No

Do we have your permission to call you at your work? □ Yes □ No

Work status

□ Full time
□ Part time
□ Retired
□ Not employed
□ Disabled

Other contact person_____ Contact Phone _____

Is an **attorney** involved in this case? □ Yes □ No Name _____ Phone _____
If your attorney has not requested an independent examination, we will only be responding to the referral questions of your referring clinician. We might not address specific medico-legal questions your attorney may have. If you have any questions about this issue, you should contact your attorney.
Do you want a copy of your report sent to your attorney? □ Yes □ No

Is there a **guardian** for the patient? □ Yes □ No a **conservator**? □ Yes □ No

If yes, Name _____
Phone_____

X_____
Signature of patient/responsible party Date

INSURANCE INFORMATION

If you are unable to bring your insurance card to your appointment, please complete the following.

Industrial Injury? ☐Yes ☐No If yes, Claim # _____

If industrial injury, Claims Representative Name: _____

Phone_____

Primary Carrier (Health ☐ Auto ☐) _____ Group Number _____

Name of insured _____ ID Number _____

Send Claim To _____
Street City State Zip

Secondary Carrier (Health ☐ Auto ☐) _____ Group Number _____

Name of Insured _____ ID Number_____

Send Claim To _____
Street City State Zip