

**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 \_\_\_\_\_ Social Security # \_\_\_\_\_ E-mail \_\_\_\_\_

Message Phone \_\_\_\_\_ Driver's License # \_\_\_\_\_ Marital Status M S D W

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

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 \_\_\_\_\_

Is the case being litigated? Yes No If yes, Attorney's Name \_\_\_\_\_

Referring Physician \_\_\_\_\_ Your Primary Doctor/Family Physician \_\_\_\_\_

Caregiver or Care Home Name (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Date of your last: MRI \_\_\_\_\_ CT Scan \_\_\_\_\_ X-ray \_\_\_\_\_ EEG \_\_\_\_\_ Ultrasound \_\_\_\_\_

**INSURANCE INFORMATION** Circle all methods of payment that apply.

Private Insurance	Worker's Comp Insurance (see above)	Motor Vehicle Accident Insurance (see above)
Medicare	Medi-Cal/CMSP	None
		Other _____

<b>PRIMARY INSURANCE</b>	<b>SECONDARY INSURANCE</b>
Name _____	Name _____
Policy _____	Policy _____
Group# _____	Group# _____
Address _____	Address _____
Name of Insured _____	Name of Insured _____

**ASSIGNMENT AND MEDICAL RECORDS RELEASE**

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**

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 \_\_\_\_\_