

**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 Ph: _____ Race _____ Ethnicity: (Hispanic) or (Non Hispanic or Latino) Marital Status: M S D W
Patient's Employer _____ Occupation _____ Driver's License # _____
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 _____
PRIMARY INSURANCE **SECONDARY INSURANCE**
Name _____ Name _____
Policy _____ Policy _____
Group# _____ Group# _____
Address _____ Address _____
Name of Insured _____ Name of Insured _____

ASSIGNMENT AND MEDICAL RECORDS RELEASE: All patients, please read and sign below.
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: Patients with Medicare insurance, please read and sign below.
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** _____