NEUROLOGY OFFICE

JOSEPH KANDEL, M.D.

& ASSOCIATES

PATIENT REGISTRATION

Patient Name_____

Address_____City/State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

SS#_____DOB_____Sex_____Marital Status_____

Emergency Contact_____Phone number_____

Patients Employer/School_____Occupation_____

INSURANCE CARDHOLDER OR RESPONSIBLE PARTY INFORMATION

Subscriber/Guarantor Name_____Relationship_____

Subscriber/Guarantor DOB_____SS#_____

Primary Insurance_____Policy #_____Group#_____

Secondary Insurance_____Policy#_____Group#_____

INJURY INFORMATION

Date of Injury_____Type of Injury(ex. Auto, fall, bicycle)_____

Claim number_____ Claim Rep_____Phone#_____

Are you working at this time: Yes____No_____ Effective Date of Disability_____

IS THIS A WORK RELATED INJURY? YES_____ NO_____

Employer at time of injury_____Date of injury_____

AUTHORIZATION, RELEASE & GUARANTEE OF ACCOUNT

I acknowledge that I am responsible for payment in full to Neurology Office, Joseph Kandel MD & Associates, for services rendered. I also authorize that benefits from insurance companies be paid directly to Neurology Office, Joseph Kandel MD & Associates. I authorize my attending physician to release any information required by my insurance carrier.

Signature_____ Date_____