CAPITAL NEUROLOGY
4250 CRUMS MILL ROAD STE 102
HARRISBURG, PA 17112-2889
(717) 649-0211

PATIENT REGISTRATION FORM (PAGE 1 OF 2)

TODAY'S DATE: **PRIMARY CARE PHYSICIAN:**

PATIENT INFORMATION

LAST NAME:	**FIRST NAME:**	**MI:**
IS THIS YOUR LEGAL NAME? Y ☐ N ☐	**MARITAL STATUS:**	
IF N ABOVE, LEGAL NAME?	**DATE OF BIRTH:** _____/_____/_____	**AGE:**
	PRONOUNS:	**SEX:**
ADDRESS:		
CITY:	**STATE:**	**ZIP:**
HOME PHONE: ( ) _____ - _____	**CELL PHONE:** ( ) _____ - _____	**SSN:**
EMAIL:		
OCCUPATION:	**EMPLOYER:**	
EMPLOYER PHONE: ( ) _____ - _____	**REFERRED BY:**	
OTHER FAMILY MEMBERS SEEN HERE:		

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE? Y ☐ N ☐	**RESPONSIBLE PARTY (RELATION):**	
RESPONSIBLE PARTY (INSURED'S NAME):		
IS THIS PARTY A PATIENT HERE? Y ☐ N ☐	**DATE OF BIRTH:** _____/_____/_____	**AGE:**
OCCUPATION:	**EMPLOYER:**	
EMPLOYER PHONE: ( ) _____ - _____	**EMPLOYER ADDRESS:**	
GROUP #:	**POLICY #:**	**SSN:**
INSURER:	**CLAIMS PHONE:** ( ) _____ - _____	**CO-PAY:**
	Please give your insurance card to the receptionist.	

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PATIENT REGISTRATION FORM (PAGE 2 OF 2)

TODAY'S DATE: **PRIMARY CARE PHYSICIAN:**

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE? Y ☐ N ☐	**RESPONSIBLE PARTY (RELATION):**	
RESPONSIBLE PARTY (INSURED'S NAME):		
IS THIS PARTY A PATIENT HERE? Y ☐ N ☐	**DATE OF BIRTH:** _____/_____/_____	**AGE:**
OCCUPATION:	**EMPLOYER:**	
EMPLOYER PHONE: ( ) _____ - _____	**EMPLOYER ADDRESS:**	
GROUP #:	**POLICY #:**	**SSN:**
INSURER:	**CLAIMS PHONE:** ( ) _____ - _____	**CO-PAY:**
	Please give your insurance card to the receptionist.	

IN CASE OF EMERGENCY

NAME OF LOCAL CONTACT NOT AT SAME ADDRESS:		
RELATIONSHIP TO PATIENT:	**HOME PHONE:** ( ) _____ - _____	**EMAIL:**
	WORK PHONE: ( ) _____ - _____	
ADDRESS:		
CITY:	**STATE:**	**ZIP:**

The information completed on this form 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 Capital Neurology to release any information required to properly process my claims.

_____	_____	_____
Name of patient	MRN#	Date of birth
_____	_____	_____
Signature of patient/responsible party	**Relationship (if applicable)**	**Today's date**