SOUTHWEST NEUROLOGY, P.A.

Patient Registration Form

Patient Name: ________________________________ Date of Birth: _____/________/_________
Patient's home address: ____
City: _____________________ State: _____ Zip: ___________ (H) phone ___________________
Patients SSN (required) _______/______/________ (C) phone ___________________
Patient e-mail: ____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

☐ Retired ☐ Unemployed ☐ Disabled
Employer: ___________________________________(W) phone: ____________Ext:_________

Primary Care Doctor: _____________________

Who can we thank for referring you to our office? Website ___ Facebook ___ Insurance ___
Friend or Family Member ___________________ Referring Physician _____________________

Primary Insurance Information

Insured Name: ______________________________ Relationship to patient: ☐ same ☐ spouse ☐ parent
Birthdate: ____/______/______ Group Employer Name: _______________________________________
Insurance Co. Name: __________________________ Group # ___________ ID# _________________

Supplemental Insurance Information

Insured Name: ______________________________ Relationship to patient: ☐ same ☐ spouse ☐ parent
Birthdate: ____/______/______ Group Employer Name: _______________________________________
Insurance Co. Name: __________________________ Group # ___________ ID# _________________

Work Compensation/ Accident/ Injury Information

Date of Injury: ___________ Claim #: __________________
Insurance Co. Name: ________________________ Adjuster name: ________________________
Adjuster phone # : __________________
Address for claims: ____
City, State, Zip:____

Consent for Treatment: I authorize Southwest Neurology, PA to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his opinion, deemed necessary or advisable for my care.
Release of Medical Records: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical records may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.
Insurance Authorization: I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also herby authorize payment of insurance benefits otherwise payable to me directly to the doctor.
Responsibility of Payment: We make every attempt at verifying your benefits for possible services that may be provided, however the benefits that are quoted from your insurance are not a guaranty of payment. If your insurance does not cover all of the visit charges, you are responsible for any remaining balance. Payment is due at the time of service.
No Show Policy: 48 Hour notice must be given to cancel a scheduled appointment. Otherwise a $25 no-show fee will be charged follow up appointments and $50 no-show fee for all procedure appointments or new patient appointments.
Walter Taylor, M.D. does have ownership interest in Lake Pointe Hospital but as a patient you do have the right to choose the provider for your health care services. Therefore, you have the option to use a health care facility other than Baylor Scott and White Lake Pointe Hospital and will not be treated differently by our office or providers.

____ ___________________________
Signature of patient or guardian if patient is a minor Date