

**SOUTHWEST NEUROLOGY, P.A.**  
**WALTER L. TAYLOR, III, M.D.**

**Patient Registration Form**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient's home address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **(H) phone** \_\_\_\_\_

**Patients SSN (required)** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**(C) phone** \_\_\_\_\_

Single  Married  Divorced  Widowed  Minor \*  Retired  Unemployed  Disabled

\*If patient is MINOR –under 18yrs age only **Parent SSN REQUIRED** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Employer:** \_\_\_\_\_ **(W) phone:** \_\_\_\_\_ **Ext:** \_\_\_\_\_

**Employer address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_ **Primary Care Doctor:** \_\_\_\_\_

**Primary Insurance Information**

**Insured Name:** \_\_\_\_\_ **Relationship to patient:**  same  spouse  parent

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Group Employer Name:** \_\_\_\_\_

**Insurance Co. Name:** \_\_\_\_\_ **Group #** \_\_\_\_\_ **ID#** \_\_\_\_\_

**Medicare ID #:** \_\_\_\_\_

**Supplemental Insurance Information**

**Insured Name:** \_\_\_\_\_ **Relationship to patient:**  same  spouse  parent

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Group Employer Name:** \_\_\_\_\_

**Insurance Co. Name:** \_\_\_\_\_ **Group #** \_\_\_\_\_ **ID#** \_\_\_\_\_

**Medicare ID #:** \_\_\_\_\_

**Work Compensation/ Accident/ Injury Information**

**Date of Injury:** \_\_\_\_\_ **Claim #:** \_\_\_\_\_ if applicable.

**Specify area of injury:**  Neck  Shoulder  Arm  Elbow  Wrist  Finger  Upper Back  Lower Back  Hip  
 Leg  Knee  Ankle  Foot  Head  Toe  Right  Left or  Bilateral

**Contact person:** \_\_\_\_\_ **phone # :** \_\_\_\_\_

**Insurance Co. Name:** \_\_\_\_\_ **Adjuster phone # :** \_\_\_\_\_

**Address for claims:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Brief Description of accident:** \_\_\_\_\_

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**Consent for Treatment:** I authorize Walter L. Taylor, M.D. 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 hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

**Responsibility of Payment:** If your insurance does not cover all of the visit charges, you are responsible for remaining balance. A \$25 charge will be assessed for each date of service when turning the unpaid amount over to IC Systems Collection Agency. There is a \$25 fee for each NSF check.

**No Show Policy:** 24 Hour notice must be given to cancel your appointment; otherwise a \$25 no-show fee will be charge for confirmed appointments.

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date