

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 FT/PT Student

Patient Employer: _____ **(W) phone:** _____

Employer address: _____ **City:** _____ **State:** _____ **Zip:** _____

Retired Unemployed Disabled

Referring Doctor: _____ **Primary Care Doctor:** _____

Primary Insurance Information

(copy of insurance card required)

Insured Name: _____ **Relationship to patient:** same spouse parent

Birthdate: ____/____/____ **Name of Insured Group:** _____

Insurance Co. Name: _____ **Group #** _____ **ID#** _____

Medicare ID #: _____

Secondary Insurance Information

(copy of insurance card required)

Insured Name: _____ **Relationship to patient:** same spouse parent

Birthdate: ____/____/____ **Name of Insured Group:** _____

Insurance Co. Name: _____ **Group #** _____ **ID#** _____

Medicare ID #: _____

Workers Compensation Information

(Required)

Date of Injury: _____ **Claim #:** _____

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 @ job: _____ **phone # :** _____

Work Comp Insurance Co. Name: _____ **Adjuster phone # :** _____

Address for claims: _____

City, State, Zip: _____

Brief Description of accident: _____

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 turning the unpaid amount over to ICS Collection Agency.

Signature of patient or parent if minor

Date