PACIFIC NEUROSCIENCE MEDICAL GROUP

Registration Information

Patient Information

Last name	First name		M.I.	Former or maiden name
Social security number	Sex NS	Birth date	Marital status Not specified	Driver's license number

Home address	City	State	Zip	Home phone
Other address (e.g., work)	City	State	Zip	Other phone

Occupation/title	Employer's name

Persons to Contact in Case of Emergency

Last name, First	Relationship to patient	Home phone	Cell phone
Last name, First (someone not living with you)	Relationship to patient	Home phone	Cell phone

Financially Responsible Party (Guarantor)

Last name, First	Relationship to patient	Social security number	DI Number

Address	City	State	Zip	Other phone

Insurance Information

Primary	Subscriber name (if other than patient)	Birth date	Social security number
Secondary	Subscriber name (if other than patient)	Birth date	Social security number

FINANCIAL DISCLOSURE

Pacific Neuroscience Medical Group physicians receive or have received, directly or indirectly, grant support from pharmaceutical companies for the conduct of clinical research trials.

PRIVACY STATEMENT

- **INSURANCE COMPANIES:** By signing below, and entering into a doctor-patient relationship with Pacific Neuroscience Medical Group, you give your permission for us to furnish information concerning your medical condition to your insurance companies.
- **EMERGENCIES:** There may be unexpected situations that arise that require us to share medical information with other health professionals. Examples include emergency hospitalizations, emergency room visits, and other serious or potentially life-threatening situations. In these situations, your privacy will be considered in the context of your overall health care and safety.
- **OTHER:** In the course of providing your medical care, it may be advantageous to discuss your case with other physicians, other healthcare professionals, family, close friends, or caregivers In order to protect your privacy, we ask that you indicate in the spaces below the names of individuals with whom we may share your medical information.

Referring physician	Phone	Fax
Primary care physician	Phone	Fax
Other physician	Phone	Fax
Other (e.g., Spouse)	Phone	Fax

CONSENT TO TREATMENT, INFORMATION RELEASE, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY

- By signing below, I hereby consent to be treated by the staff of Pacific Neuroscience Medical Group, now and in the future.
- By signing below, I hereby authorize Pacific Neuroscience Medical Group to furnish information concerning my medical condition(s) to insurance companies and other individuals as indicated above. A photocopy of this authorization will be valid as the original.
- By signing below, I direct my insurer(s) to pay, without equivocation directly to Pacific Neuroscience Medical Group, all benefits due Pacific Neuroscience Medical Group as a result of any claims.
- By signing below, I acknowledge that I will be charged a cancellation fee up to $100 for appointments cancelled or broken without 24 hours advance notice.
- By signing below, I acknowledge that although I may be covered by insurance, I am aware that I am personally responsible for all charges.

Patient name _____ Patient signature _____ Date _____