HOPE Neurology

# Sibyl Wray, MD / David W. Brandes, MD

## REGISTRATION FORM

| Primary Care Physician | Date |
|---|---|

### PATIENT INFORMATION

| Patient's last name First Middle | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date / / | Age | Sex ❑ M ❑ F |
|---|---|---|---|---|---|

| Street Address/P.O. Box | Social Security # | Home Phone ( ) |
|---|---|---|

| City | State | ZIP Code | Cell Phone ( ) |
|---|---|---|---|

| Email Address |
|---|

| Occupation | Employer | Employer Phone ( ) |
|---|---|---|

| Referring Doctor's Phone | Referring Doctor's Address: |
|---|---|

| Pharmacy Name | Pharmacy Number |
|---|---|

### INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill | Birth Date / / | Address (if different) | Home Phone ( ) |
|---|---|---|---|

| Is this person a patient here? ❑ Yes ❑ No |
|---|

| Occupation | Employer | Employer Address: | Employer Phone ( ) |
|---|---|---|---|

| Is this patient covered by insurance? ❑ Yes ❑ No | Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other |
|---|---|

| Please indicate primary insurance | ❑ Blue Cross | ❑ Medicare | ❑ United Healthcare | ❑ Cigna | ❑ Cariten |
|---|---|---|---|---|---|
| ❑ Heritage | ❑ American Health | ❑ John Deere | ❑ Aetna | ❑ Other | |

| Subscriber's Name | Subscriber's S.S. # | Birth Date / / | Group # | Policy # | Co-payment $ |
|---|---|---|---|---|---|

| Name of secondary insurance (if applicable) | Subscriber's Name | Group # | Policy # |
|---|---|---|---|

| Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other |
|---|

### IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address) | Relationship to patient | Home Phone ( ) | Work Phone ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be assigned and paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sibyl Wray MD Neurology, PC / Sweetwater Neurology or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*