The Neurology Center of South Delaware, P.A.
24488 Sussex Highway, Suite 6
Seaford, DE 19973
Phone (302)628.7730
Fax (302)628.7791

21635 Biden Ave, Suite 203
Georgetown, DE 19947
Phone (302)858.4524
Fax (302)858.4766

PATIENT REGISTRATION

PATIENT				
Name (Last, First, MI)	Sex M F	Birthdate	Social Security Number	Marital Status- M S W
Mailing Address	City	State	Zip Code	
Employer	City	State	Zip Code	
Home Phone	Cell Phone	Work Phone		
Email Address	How did you hear about us? Circle one Newspaper/Magazine Online Friend/Family Other Physician			
Reason for Visit	Referring Physician	Primary Care Physician		

EMERGENCY CONTACT- For emergency purposes only. Not a HIPPA consent.		
Name	Relationship	**Phone (Circle one - Work, Home, Cell)**

AUTOMOBILE ACCIDENT – Is this visit the result of an automobile accident? **YES** or **NO**
WORKMAN'S COMPENSATION – Is this visit the result of injury on the job? **YES** or **NO**

INSURANCE INFORMATION				
Primary Insurance Company	**Subscriber's Name**	Relationship	Policy Number	Group #
Second Insurance Company	**Subscriber's Name**	Relationship	Policy Number	Group #

If you are not the policy holder complete policy holder information below.

POLICY HOLDER INFORMATION OR RESPONSIBLE PARTY IF OTHER THAN SELF OR MINOR				
Name (Last, First, MI)	Social Security Number	Birthdate	Sex M F	Marital Status
Mailing Address	City	State	Zip Code	Home Phone ( )
Employer	City	State	Zip Code	Work Phone ( )

I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement.

I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies including the Health Care Financing Administration, for the purpose of filing and payment of all medical claims. I authorize payment of medical benefits to The Neurology Center of South Delaware. I recognize and accept personal responsibility for my balance on my account where applicable.

This authorization applies to all occasions of services for all insurance companies until revoked in writing. I permit a copy of this release to be used in place of an original for insurance purposes.

_____ _____

Signature of insured or authorized person, patient or parent if minor **Date**

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Permission to Release and Obtain Medical Information

With your consent and with respect to your privacy, The Neurology Center of South Delaware will obtain and disclose medical information/records from prior healthcare providers, healthcare facilities and physicians we refer you to, as well as your insurance companies for authorization, payment processing, and contractual obligations.

Please list/update additional individuals/family members you authorize us to inform/discuss your medical condition/diagnosis, treatment and insurance & payment information to:

Name of Persons, Employers, Organizations	**Relationship**
_____	_____
_____	_____

If you do NOT wish for our office to release any information to family members /additional individuals please initial here: ____

Continuity of Care

The Neurology Center of South Delaware, P.A. requires that you are under the current care and designate a primary care provider in the event that our neurologists are unavailable.
Please list your current primary care/family physician: _____

Prescription Refills/ Requests

To prevent exhausting a supply of medication, please contact us 2 weeks prior to running out. Be prepared when calling to leave the name of the medication, dosage, and pharmacy or mail order information you want the medication request sent to. ALLOW 72 BUSINESS HOURS FOR US TO COMPLETE YOUR REQUEST.

Have you signed up for Patient Portal?

If you would like to register for Patient Portal, please submit your name and email address. We will update your information and send you an email to notify you that your Patient Portal is active.

Email: _____
(Please Print Clearly)

Patient Financial Policy

Our office charges $10 for cancellations/No-Shows within 24 hours.

It is your responsibility to update all address, phone number, insurance, and contact information at every visit. It is your responsibility to have an insurance referral for your visit, if it is required by your insurance. All copays or deductible payments are due at the time of your visit.

Our office has a limited amount of time to submit charges to your insurance for payment. Failure to update your information or provide a referral may result in balances owed by you, if we are unable to obtain payment by your insurance.

All balances are due in full within 30 days of your first bill. Any unpaid balances over 90 days are eligible to be sent to collections.

Patient Signature_____ **Date**_____/_____/_____

Signature indicates you read, understand and authorize as stated in this form.

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Patient Name: _____ DOB: _____

Please explain problems/symptoms you are experiencing today:

_____
_____
_____

Allergies

Please list any NEW allergies since the last time you were seen including, Medications, Latex, etc.

Allergy	Reaction

Medications

Please list all NEW medications including over-the-counter:

Medication	Dose

Please list any NEW surgical procedures you have had since your last appointment

Procedure/Operation	Date

Your Current Height: ____ Weight: _____

Have you smoked at least 100 cigarettes in your entire life: Yes / No
Do you currently smoke cigarettes: Yes / No
Do you use smokeless tobacco: Yes / No
Are you at risk for secondhand smoke: Yes / No
Do you drink alcohol: Yes / No

Please check if you have/had a personal history or family history of any of the following:

- ☐ Headaches
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Fevers
- ☐ Arthritis
- ☐ Back Pain
- ☐ Dizziness/Lightheadedness
- ☐ Neck Pain
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Shortness of Breath
- ☐ Sleep Apnea

Patient Signature: _____ Date: _____