AUSTIN NEUROMUSCULAR CENTER

PATIENT REGISTRATION FORM

PATIENT INFORMATION

_____

Name (First, M.I., Last)

_____ _____

Date of Birth Age

Gender: Male / Female (circle one) **Marital Status:** S M W D (circle one) Intersex / Transgendered

_____

Address (number, street, city, state, zip)

_____ _____

Phone Driver License #

_____ _____

Employer Phone

_____

Employer Address (number, street, city, state, zip)

_____ Full-Time / Part-Time **(circle one)**

If Student, School Name

_____ _____

Emergency Contact Phone

_____

Referring Physician Name

RESPONSIBLE PARTY

_____ _____

Name Relationship to Patient

_____ _____

Address (number, street, city, state, zip) Phone

p : (512) 920-0140 | f : (512) 920-0142
www.austinneuromuscle.com

4705 Spicewood Springs Rd.
Austin, TX 78759

AUSTIN NEUROMUSCULAR CENTER

Employer _____ Phone _____

Employer Address (number, street, city, state, zip) _____

INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address (number, street, city, state, zip) _____

Group # _____ Certificate or ID# _____

Insured Name _____ Date of Birth _____

Relationship To Patient: Self / Spouse / Partner / Dependent **(circle one)**

Insured Employer _____ Phone _____

Employer Address (number, street, city, state, zip) _____

I hereby assign, transfer, and set over to Austin Neuromuscular Center physicians & associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges, whether they are covered by insurance.

Patient's Printed Name _____ Patient Signature _____

Date of Signature _____

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