TRIANGLE NEUROPSYCHOLOGY SERVICES, PLLC
3310 Croasdaile Drive, Suite 400, Durham, NC 27705
1540 Sunday Drive, Suite 200, Raleigh, NC 26707

New Patient Registration

Date: ______________________ Who Referred You? ______________________

Please Answer ALL Questions

Patient Name: First: __________ Middle: __________ Last: __________
Social Security Number: __________ Driver's License Number: __________ State Issued: _____
Contact Information: Home Phone: __________ Mobile Phone: __________
Email: ______________________________
Address: Street: ______________________________ PO Box #: __________
City: __________ State: __________ Zip Code: __________
****May we contact you YES or NO:** Best way to reach you: Home Phone Mobile Phone Email Address

Demographic Information: Birthdate: Month: ________ Day: _____ Year: _______ Gender: Male Female
Race/Ethnicity: __________ Marital Status: __________ Name of Spouse/Partner: __________

Employment Information: Status: Full-time Part-time Not employed
Employer: ______________________________
Work Address: Street: ______________________________ Suite #: __________
City: __________ State: _______ Zip Code: _______ Phone Number: __________

Financial Information: Person Responsible for Bill: Self: Other (If other, please complete the following)
Name: __________ Relationship to Patient: ______________________________
Contact Phone Number: __________ Birthdate: Month: __________ Day: ______ Year: _______
Social Security Number: __________ Driver's License Number: __________ State Issued: _____
Employer: ______________________________
Work Address: Street: ______________________________ Suite #: __________
City: __________ State: _______ Zip Code: _______ Phone Number: __________

Emergencies: Person to Contact in Case of an Emergency: ______________________________
Contact Phone Number: __________ ****May we contact you ☐ YES or NO:**
Address: Street: ______________________________ PO Box #: __________
City: __________ State: __________ Zip Code: __________

Insurance Information

1. Primary Insurance: Insurance Company: ______________________________
Subscriber ID: __________ Medicare Number: __________
Group Number: __________ Policy Holder Name: __________
Policy Holder Social Security #: __________ Policy Holder Date of Birth: __________

PLEASE CONTINUE AND SIGN ON THE BACK

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com

2. Secondary Insurance: Insurance Company: ______________________________

Subscriber ID: ______________________ Medicare Number: ______________________

Group Number: ______________________ Policy Holder Name: ______________________

Policy Holder Social Security #: ______________ Policy Holder Date of Birth: ______________

Authorization Regarding Personal Health Information and Payment –

_______ (initials) I hereby authorize Triangle Neuropsychology Services, PLLC to release medical information to insurance carriers and its agents concerning my illness and treatments.

_______ (initials) I hereby authorize Triangle Neuropsychology Services, PLLC to release medical information in such cases, to my employer, if applicable for worker's compensation cases or other work-related medical cases. Unless otherwise restricted by applicable law, this authorization to release medical records includes the release of medical record information for all heath care services that previously have been or will in the future be provided by Triangle Neuropsychology Services, PLLC.

_______ (initials) I authorize Triangle Neuropsychology Services, PLLC to use my email address for contact purposes only.

_______ (initials) I hereby authorize payments for medical services rendered to myself or authorize Medicare benefits, if applicable, to be made either to me or on my behalf to the above names physician. I understand that I am responsible for any amount not covered by insurance. A photocopy of this authorization and assignments shall be considered as valid as the original.

______________________________ ______________________ ______________________

Signature of Patient** or Legal Representative** Date Time

______________________________ ______________________

Relationship to Patient*** Signature of Witness

***If you are signing this form on behalf of the Patient, you must state your relationship to the patient. If you are the Health Care Power of Attorney for a Patient, you must provide legal documentation to this effect.

**If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, legal guardian, or other person acting loco parentis who has the authority to act on the minor-Patient's behalf. By signing this form for someone else, you as the parent, legal guardian, a party acting as loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

Phone: 919-384-9682 Fax: 919-384-9683 www.TriangleNeuropsychology.com