

Patient Registration

Date _____

Name (Last, First MI) _____ Home Phone _____

Address _____ Apt. # _____ Cell Phone _____

City/State/Zip _____ Work Phone _____

Sex: M F Date of Birth _____ Soc. Sec. No. _____

Marital Status: Single Married Divorced Widowed Other _____

Primary Care Provider (PCP) _____ Phone _____

Referring Doctor _____ Phone _____

Emergency Contact _____ Phone _____

Relationship: Spouse Parent Child Neighbor Other _____

Health Insurance Information

****Please present insurance cards to the front desk.****

Primary Insurance _____

Secondary Insurance _____

Name of Insured _____

Name of Insured _____

Relationship to Patient:

Relationship to Patient:

Self Spouse Parent Other _____

Self Spouse Parent Other _____

Has deductible been met: Yes No

Has deductible been met: Yes No

Notice of Privacy Practices

Your name and signature below indicates that you have been provided a copy of East Bay Neurosurgery and Spine's Notice of Privacy Practices on the date and time indicated. If you have any questions regarding the information set forth in this notice or would like a copy of the Notice of Privacy Practices, contact the patient care coordinator.

Signature _____ Date _____

Printed Name _____ Time received _____ am / pm