NEURO ORTHO NYC

ONE TEAM

Multiple Specialties

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New Patient Registration

DATE OF VISIT _____

PATIENT INFORMATION

PATIENT NAME _____

DOB _____ SEX ☐ Male ☐ Female

ADDRESS _____

CELL PHONE _____ HOME PHONE _____

SOCIAL SECURITY # _____ MARITAL STATUS _____

EMPLOYER _____

EMERGENCY CONTACT _____

EMAIL ADDRESS _____

REFERRING PHYSICIAN _____

PRIMARY CARE PHYSICIAN _____

PREFERRED PHARMACY _____

PRIMARY INSURANCE _____ ID # _____

SECONDARY INSURANCE _____ ID # _____

WORKER'S COMP

INSURANCE CARRIER _____

CARRIER ADDRESS _____

CLAIM # _____ DOI _____ WCB # _____

ADJUSTOR NAME & PHONE _____

ATTORNEY NAME / PHONE _____

NO FAULT

INSURANCE CARRIER _____

CARRIER ADDRESS _____

CLAIM # _____ DOA _____

ADJUSTOR NAME & PHONE _____

ATTORNEY NAME / PHONE _____

I verify the accuracy of the above information. I request the provider bill and request payment directly from my insurance company. I understand that I will be responsible for any co-insurance/deductible that my insurance company applies to my claim(s).

At NeuroOrthoNYC, we are committed to providing you with high-quality, efficient, and compassionate medical care. To help us spend more time focusing on your health and less time on administrative tasks, we utilize secure Artificial Intelligence (AI) technologies to assist with clinical documentation and phone communications.

PATIENT SIGNATURE _____ DATE _____