NORTHWEST BRAIN & SPINE

NEW PATIENT REGISTRATION

2115 NE WYATT COURT, SUITE 201
BEND, OREGON 97701
T: 541-585-2400 F: 541-585-2407
WWW.NEURONWBS.COM

REFERRED BY? _____ PRIMARY CARE PHYSICIAN _____

NAME _____ DATE OF BIRTH _____ ☐ M ☐ F

MAILING ADDRESS _____ EMAIL ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ OCCUPATION _____

PREFERRED PHARMACY _____

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE NUMBER _____

MARITAL STATUS	☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐ PARTNER ☐ OTHER
PREFERRED LANGUAGE	☐ ENGLISH ☐ OTHER: _____
RACE	☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ NATIVE HAWAIIAN ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ HISPANIC ☐ OTHER PACIFIC ISLANDER ☐ OTHER RACE ☐ UNREPORTED/REFUSE TO REPORT
ETHNICITY	☐ HISPANIC OR LATINO ☐ **NOT** HISPANIC OR LATINO ☐ UNREPORTED/REFUSE TO REPORT

MEDICAL INSURANCE:

INSURANCE NAME _____ SUBSCRIBER NAME _____

SUBSCRIBER DATE OF BIRTH _____ RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

SUBSCRIBER ID _____ SUBSCRIBER SOCIAL SECURITY # _____ GROUP ID _____

AGREEMENT AND CONSENT

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits directly to Northwest Brain and Spine for professional services rendered. I understand that Northwest Brain and Spine will bill my insurance as a courtesy, but I am responsible for any balance not covered by my insurance.

I give permission to the physicians at Northwest Brain and Spine to administer treatment, obtaining necessary health information which includes medication lists from other providers and pharmacies and to perform such procedures. by Oregon law, I am entitled to know the procedure, alternatives and risks involved, with a detailed explanation if so desired.

I understand that undesirable outcomes MAY OCCUR with procedures and adverse side effects or reactions MAY OCCUR with medications. I will be responsible for following the doctor's instruction and that my non-compliance may result in a poor outcome and may be grounds for termination of the doctor/patient relationship. I will also be responsible for continuing any recommended follow up care and for any poor outcome which may result from the lack of doctor recommended follow up care.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY _____ DATE _____