

East Carolina Neurology Inc.
Patient Registration & Billing Information

Responsible for Payment Name: _____

Must be 18 years or older

Last

First

Middle Initial

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone _____

Social Security # _____ Date of Birth _____

Patient Name: _____

Last

First

Middle Initial

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone _____

Social Security # _____ Cell Phone _____

Date of Birth _____ Sex _____ Marital Status _____ Race _____

Patient Employer: _____ Phone # _____

Address: _____ City _____ State _____ Zip _____

Occupation/Job Title: _____

Is your visit the result of an auto accident? _____ Date of accident _____

Insurance Information

If Workers' Compensation please skip to the next page. Medicare & Medicaid addresses are not required.

Primary Insurance Name: _____ Phone # _____

Claims Address: _____ City _____ State _____ Zip _____

Policy ID _____ Group# _____

Relationship to Patient (Circle One) Self Spouse Child Other _____

Policy Holder Information

Name: _____

Last

First

Middle Initial

Mailing Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Sex __ Marital Status __ Race ____

Name of Employer: _____ Address: _____

City _____ State _____ Zip _____ Phone _____

