

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 \_\_\_\_\_

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**Patient Name:** \_\_\_\_\_

Last

First

Middle Initial

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Race \_\_\_\_\_

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Patient Employer: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation/Job Title: \_\_\_\_\_

Is your visit the result of an auto accident? \_\_\_\_\_ Date of accident \_\_\_\_\_

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**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 \_\_\_\_\_

