

**Maryland Brain & Spine Registration Form**

Today Date: \_\_\_\_\_

**Patient Information:**

First, MI, Last Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex: \_\_M\_\_F Date of Birth \_\_\_\_\_ Marital Status \_\_M\_\_S\_\_D\_\_W

Work Phone #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name & Phone # of Emergency Contact: \_\_\_\_\_

Referring Physician Name & Tel#: \_\_\_\_\_

Primary Physician Name & Tel #: \_\_\_\_\_

**Primary Insurance Company Name:** \_\_\_\_\_

Claim Address: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy/Subscriber/SS #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Subscriber Name if Different Than Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

**Secondary Insurance Company Name:** \_\_\_\_\_

Claim Address: \_\_\_\_\_

\_\_\_\_\_ Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy/Subscriber/SS #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Subscriber Name if Different Than Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Is visit related to a \_\_\_ Work or \_\_\_ Auto Accident? \_\_\_ Yes or \_\_\_ No

**Workers' Comp Information if Work Related**

Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

Workers' Comp Carrier Name: \_\_\_\_\_

Claim Address: \_\_\_\_\_

Employer (Company) Name: \_\_\_\_\_

Name of Adjuster Spoke to & Tel #: \_\_\_\_\_

Accepted Diagnosis from Workers' Comp: \_\_\_\_\_

**Auto Insurance Information if Auto Accident Related**

Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

Auto Insurance Carrier Name: \_\_\_\_\_

Claim Address: \_\_\_\_\_

Name of Adjuster & Tel #: \_\_\_\_\_

**Are you represented by an attorney related to your accident? \_\_\_ Y \_\_\_ N**

Name & Tel # of Attorney: \_\_\_\_\_

\_\_\_\_\_ Lien Signed?  Yes  No

**\*\*VERY IMPORTANT\*\***

Maryland Brain and Spine will communicate with your referring doctor and your primary care physician. Please provide us with their names and mailing addresses below.

**Primary Care Physician:** \_\_\_\_\_

Street \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Phone number \_\_\_\_\_ Fax \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

Street \_\_\_\_\_

City / State / Zip \_\_\_\_\_

Phone number \_\_\_\_\_ Fax \_\_\_\_\_