



Brain & Spine Specialists
Neurological Associates, Inc.

Suite 400 General Medical Pavilion
415 Morris Street Charleston, WV 25301
304-344-3551 Fax 304-342-6927
www.wvneuro.com

For Office Use Only	
Chart #	_____
Doctor	_____

Registration Information

Full Legal Name (Please print in ink throughout this form)	Maiden or Other Name	Date
()	()	

Telephone – If none, please list one of friend or relative **Second contact phone number**– Cell phone, work, neighbor or relative.
Please note: It is very important to have a contact number (We cannot return calls with numbers that have Call Block or Call Intercept)
Your appointment may have to be rescheduled at last minute due to Emergency Surgery or Trauma.

Address: Street (If P.O. Box, please include street address)	City	State	Zip
Single or Married	M F		
Birth Date	Age	(Circle Status)	Sex (Circle One)
			Social Security Number

Employer's Name: _____ **Address:** _____

E-Mail Address at work or home: _____ **Work Phone:** _____

May we email your account with appointment information ? Yes or No (Circle one please)

Insurance Information Please bring all insurance cards to your appointment, we will Xerox each card at the appointment.

Primary Insurance Company: _____ Secondary Insurance Company: _____

Policy Holder Information: (If you are not the policy holder of your primary or secondary insurance we must have the following information.)

Policy Holder Name: _____ Relationship To The Policy Holder: _____

Policy Holder Employer/Company Name: _____

Policy Holder Date Of Birth: ___/___/___ Policy Holder Social Security Number: ___-___-___

ALL INFORMATION MUST BE PROVIDED OR WILL WILL HAVE TO RESCHEDULE YOUR APPOINTMENT!

Referring Physician: _____ **Address:** _____

Worker's Compensation Information (The following information is required for appointment.)

Your Employer when injured: _____ **Claim #** _____

Date of Injury: _____ **Claims Manager:** _____ **and Phone #** _____

If Accident (Non-Worker's Comp) Please Complete:
 ___ Auto or ___ Other (describe): _____

Date of Accident: _____ **Auto Insurance:** _____

Insured's Name: _____ **Policy # :** _____

Attorney: _____ **Phone # :** _____

Signature: _____ **Date:** ___/___/___



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COMMUNICATIONS CONSENT FORM

Patient Name

Date of Birth

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Work Telephone: | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> OK to leave message with information | <input type="checkbox"/> OK to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> OK to mail to my work address |
| <input type="checkbox"/> Home Telephone: | <input type="checkbox"/> OK to fax to this number: |
| <input type="checkbox"/> OK to leave message with information | |
| <input type="checkbox"/> Leave message with call-back number only | |
| <input type="checkbox"/> OK to send e-mail to this address: | |
| <input type="checkbox"/> OK to leave message at home with the following family members: | |

- _____
 Cell Phone:
- Patient information or medical records may be faxed to other Care Providers, hospitals or insurance companies if necessary.

Patient or Legal Representative Signature

Date

If a legal representative's signature appears above, please describe legal representative's relationship to the patient.