



**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

<b>For Office Use Only</b>	
Chart #	_____
Doctor	_____

## Registration Information

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

**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.

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

**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:** \_\_\_/\_\_\_/\_\_\_