

**Bakersfield Neuroscience & Spine Institute**

2601 Oswell Street, Suite 101, Bakersfield, CA 93306

Date \_\_\_\_\_

**PATIENT REGISTRATION FORM (Please Print)**

Our office policy requires that this form be updated on an annual basis.

<b>PATIENT INFORMATION</b>					
LAST NAME:	FIRST NAME:	MIDDLE:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status:
RESIDENCE ADDRESS:					
MAILING ADDRESS:					
CITY:	STATE:	ZIP CODE:			
HOME PHONE:	CELL PHONE:	WORK PHONE:			
DATE OF BIRTH:	SSN#:				SEX: M / F
EMPLOYER:	EMPLOYER ADDRESS:				
Referred to clinic by (please check box)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Dr	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other	
<b>SPOUSE / PARENT/ RESPONSIBLE PARTY INFORMATION</b>					
LAST NAME:	FIRST NAME:	MIDDLE:			
DATE OF BIRTH:	SSN#	CELL PHONE:			
EMPLOYER:	WORK PHONE:				
<b>EMERGENCY CONTACT</b>					
NAME:	RELATION:	PHONE:			
NAME:	RELATION:	PHONE:			
<b>PRIMARY INSURANCE (Provide copy of card)</b>					
INSURANCE NAME:	SUBSCRIBER'S NAME:	SUBSCRIBER'S DATE OF BIRTH:			
POLICY NUMBER:	GROUP NAME:	GROUP NUMBER:			
ADDRESS:					
PHONE:					
PATIENT RELASTIONSHIP TO SUBSCRIBER:	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER	
<b>SECONDARY INSURANCE (Provide copy of card)</b>					
INSURANCE NAME:	SUBSCRIBER'S NAME:	SUBSCRIBER'S DATE OF BIRTH:			
POLICY NUMBER:	GROUP NAME:	GROUP NUMBER:			
ADDRESS:					
PHONE:					
PATIENT RELASTIONSHIP TO SUBSCRIBER:	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILD	<input type="checkbox"/> OTHER	
<b>WORKER'S COMPENSATION</b>					
Yes		No		<b>PLEASE ASK FOR ACCIDENT FORM</b>	

**Consent for Medical Treatment:** I hereby consent to routine diagnostic procedures and medical treatment by this provider. I understand that no guarantee of results has been made. I authorize Bakersfield Neuroscience and Spine Institute to render reasonable and proper medical care by current standards.

\_\_\_\_\_  
Signature of Patient/Responsible Party\_\_\_\_\_  
Date

I hereby authorize Bakersfield Neuroscience & Spine Institute to disclose all information and records with respect to myself relating to diagnosis, treatment, prognosis, medical history, physical and mental condition and evaluation thereof to the person(s) listed below. This authorization will remain valid until revoked by me in writing.

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

 (Check in box indicates appointment confirmation only)\_\_\_\_\_  
Signature of Patient/Responsible Party\_\_\_\_\_  
Date