Diamond Headache Clinic
Treatment – and beyond

Purath
HEADACHE & NEUROLOGY

New Patient Registration Form

PATIENT'S PERSONAL INFORMATION:

Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State:_____ Zip: _____

Home phone: (___)_____ Cell phone #: (___)_____

E-mail Address: _____

PRIMARY INSURANCE INFORMATION (INSURANCE CARDS MUST BE PRESENTED AT CHECK-IN)

Name of insurance: _____

Name of Insured: _____ Relation to Patient: ☐ Self ☐ Spouse Child ☐ Other_____

Insured Date of Birth: _____ Insured ID #: _____ Group #: _____ Eff. Date: _____

SECONDARY INSURANCE INFORMATION (if applicable):

Name of insurance: _____ Name of Insured: _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ Insured Date of Birth:_____

Insured ID #: _____ Group #: _____ Eff. Date: _____

GUARANTOR INFORMATION:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____ Primary Phone Number: (_____)_____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (___)_____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby give lifetime authorization for payment of insurance benefits to be made directly to the Diamond Headache Clinic & Purath Headache & Neurology, and any assisting physicians, for services rendered. I understand that although an insurance claim has been filed on my behalf, it is not a guarantee of payment, and that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize the Diamond Headache Clinic to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE: _____ DATE: _____

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