1040 37th Place, Suite 101, Vero Beach, FL 32960, (772)205-3345 (phone), (772)205-3346 (fax)

REGISTRATION FORM
(Please Print)

Today's date:				PCP:	
PATIENT INFORMATION					
Patient's last name:	First:	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.: ( )	
P.O. box:	City:	State:		ZIP Code:	
Occupation:	Employer:			Employer phone no.: ( )	
Did a physician refer you to us? Name: ________________		Primary Language:		Ethnicity:	
How did you hear about us: (please check one box): ❑ Family ❑ Friend ❑ Close to home/work ❑ Website		Race:			

INSURANCE INFORMATION					
(Please give your insurance card and driver's license to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here?	❑ Yes ❑ No				
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance?	❑ Yes ❑ No				
Please indicate primary insurance ❑ ❑	❑ Medicare ❑	❑ BCBS ❑	❑ Cigna	❑ Aetna ❑ Other	❑ _________
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

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IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **VeroNeurospine** or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Patient Name:____ D.O.B.______________________