East Bay Neurosurgery and Spine

A Medical Corporation

Dr. Gordon Tang

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Patient Registration

Date:_____

Name (Last, First):_____ Home Phone:_____

Address: _____ Cell Phone: _____

City: _____ State:_____ Zip:_____ Work Phone: _____

Sex: [ ]M [ ]F Date of Birth:_____ SSN: _____

Email: _____

Marital Status:[ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Other: _____

Primary Care Physician:_____ Phone:_____

Referring Doctor:_____ Phone:_____

Pharmacy Name/Street/City: _____ Phone:_____

Emergency Contact:_____ Phone:_____

Relationship:[ ]Spouse [ ]Parent [ ]Child [ ]Neighbor [ ] Other: _____

Health Insurance Information

Primary Insurance: _____ Secondary Insuarance: _____

[ ]PPO [ ]HMO [ ]PPO [ ]HMO

Name of Insured:_____ DOB: _____ Name of Insured:_____ DOB: _____

[ ] Self [ ] Spouse [ ] Parent [ ] Other:_____ [ ] Self [ ] Spouse [ ] Parent [ ] Other:_____

Do you have a copay? Y/N How Much?_____ Do you have a copay? Y/N How Much?_____

Did you verify your benefits prior to visit? Y/N Did you verify your benefits prior to visit? Y/N

Are we in network according to your plan? [ ] Yes [ ] No

Workers Compensation

Name of Insurance: _____ Adjustor: _____

Adjustor Phone:_____Date of Injury: _____ Employer:_____

Employer Phone: _____ Are you currently not working due to this injury? Y/N

Notice of Privacy Practices

Your name and signature below indicates that you have been provided a copy of East Bay Neurosurgery and Spine's Notice of Privacy Practices on the date and time indicated. If you have any questions regarding the information set forth in this notice or would like a copy of the Notice of Privacy Practices, please contact our office.

Signature: _____ Date: _____

Printed Name:_____ Time received:_____