LAFAYETTE Neurology
A UNITY HEALTHCARE PARTNER

Patient Registration Form

Patient Information:

Patient Name:_____

Today's Date:_____

Address:_____City, State, Zip:_____

Home Phone :( )_____ Cell Phone: ( )_____

Date of Birth:_____Sex: ☐ M ☐ F Gender Identity: ☐ M ☐ F ☐ Both ☐ Neither

Marital Status: ☐ M ☐ S ☐ D ☐ W Social Security #:_____

Referring Doctor:_____ Primary Care Physician:_____

Race:_____ Ethnicity ☐ Hispanic ☐ Not Hispanic

Would you like to access your medical records online? ☐ Y or ☐ N

Email Address if Yes: _____
(We will send you a link with Instructions).

Employment Information:

☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Self Employed

Patient Employer:_____ Employer Phone #_____

Insurance Information

Insurance Name:_____

Policy ID#:_____Group #:_____

Address:_____Phone #:_____

Subscriber Name:_____Relationship:_____

Subscriber DOB:_____Subscriber SSN:_____

Secondary Insurance Name:_____

Policy ID#:_____Group #:_____

Address:_____Phone #:_____

Subscriber Name:_____Relationship:_____

Subscriber DOB:_____Subscriber SSN:_____

Emergency Contact Information

Name:_____ Telephone:( )_____

Relationship:_____

Is this visit related to a **MVA Accident?** ☐ Yes ☐ No If yes, Date of Accident:_____

Is this visit **Worker's Comp related?** ☐ Yes ☐ No If yes, Date of Accident:_____