REGISTRATION FORM

PATIENT INFORMATION:

DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____
LAST NAME: _____ FIRST NAME: _____MIDDLE NAME: _____
MARITAL STATUS: _____ SINGLE _____ MARRIED _____ OTHER

MAILING ADDRESS:

PO BOX NO: _____ POSTAL CODE: KY1- _____
LOCATION: _____
ADDRESS: HOUSE/APT NO: _____STREET: _____
STATE/DISTRICT: _____ COUNTRY: _____

CONTACT NUMBERS:

CELL PHONE NO. 1 (345) _____ WORK NO. (345) _____ EXT. _____
CELL PHONE NO. 2 (345) _____FAX NO. (IF ANY) (345) _____
EMAIL ADDRESS 1: _____
EMERGENCY CONTACT NAME: _____ CONTACT NUMBER: (345) _____

INSURANCE INFORMATION:

HEALTH INSURANCE COMPANY NAME: _____
GROUP NUMBER/PLAN: _____
ID/CERTIFICATE NUMBER_____
FILL-OUT IF DEPENDANT: NAME OF PRIMARY HOLDER: _____
DATE OF BIRTH OF THE PRIMARY HOLDER : MONTH ___DAY ___ YEAR __
EMPLOYER: _____(as written on the card)

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent/guarantor) have insurance coverage with _____ (name of insurance company) and assign directly to Cayman Brain and Spine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to ensure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____ (MONTH/DAY/YEAR)
SIGNATURE RELATIONSHIP TO GUARANTOR/PRIMARY HOLDER