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MEDICARE PATIENT REGISTRATION FORM

RWC [] HST [] VDL []

DATE ___ / ___ / ___

REFERRED BY _____

PCP _____

ACCOUNT NUMBER _____

Full Name Last Name First Name Middle Soc. Sec. # _____

Address _____ Driver's License # _____

City _____ State _____ Zip _____ Home phone _____

Sex [] M [] F Age _____ Birthdate _____ [] Single [] Married [] Widowed [] Separated [] Divorced

Patient Employer _____ Work phone _____

PREFERRED PHARMACIES:

1. Pharmacy Name _____ Address _____ Phone _____

2. Pharmacy Name _____ Address _____ Phone _____

PRIMARY HEALTH INSURANCE:

Insurance Co _____ ID # _____ Group # _____

Subscriber's Name _____ Subscriber's Birthdate _____ Subscriber's Soc Sec # _____

Subscriber's Employer _____ Subscriber's Work Phone _____

SECONDARY HEALTH INSURANCE:

Insurance Co _____ ID # _____ Group # _____

Subscriber's Name _____ Subscriber's Birthdate _____ Subscriber's Soc Sec # _____

Subscriber's Employer _____ Subscriber's Work Phone _____

Who is responsible for this bill? _____ I will be paying today by cash: _____ check: _____ credit card: _____

Are you currently employed? _____ Is your spouse or other family member currently employed? _____

Are you covered under an employer or union health plan? _____ Did you sustain an injury while at work? _____ Are your injuries accident related? _____

I hereby instruct and direct Medicare to pay by check made out and mailed to: East Portland Neurology, 10101 S.E. Main St., Suite 1006, Portland, Oregon 97216 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Authorizations period: from date noted below to lifetime.

Signature: _____ Date: _____