

Neurology Consultants of Kansas  
2135 N. Collective Lane  
Wichita, KS 67206-3560  
(316) 261 – 3220  
www.ncks.org

New Patient  
 Update only

**PATIENT REGISTRATION**  
***(Fill out both sides completely)***

Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

Legal Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Birth Gender:  Male  Female \*Email: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Preferred Phone:  Home  Cell

Preferred appointment reminder:  SMS Text Message (data fees may apply)  Phone Call

Marital Status:  Married  Single  Widowed  Divorced

Preferred Language:  English  Spanish  Vietnamese  Other (specify) \_\_\_\_\_

Race:  White  Black or African-American  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  Declined

Ethnicity:  Not Hispanic or Latino  Hispanic or Latino  Declined

Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Legal Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Legal Guardian?  Yes  No

**RESPONSIBLE PARTY INFORMATION (For Billing)**

Same as Patient  Same as Insured

Legal Name: \_\_\_\_\_ SSN: \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Male  Female Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

**REFERRING PHYSICIAN'S NAME:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY STATE ZIP

**PRIMARY CARE PHYSICIAN'S NAME:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY STATE ZIP

**PHARMACY NAME:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY STATE ZIP

**PRIMARY INSURANCE**

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Doctor: \_\_\_\_\_ Patient's Relation to Insured: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
(LAST) (FIRST) (MIDDLE)

**SECONDARY INSURANCE**

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Doctor: \_\_\_\_\_ Patient's Relation to Insured: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female  
(LAST) (FIRST) (MIDDLE)

**Assignment of benefits:** I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If Item 12 of HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination for the Medicare/Other Insurance company. Co-pay must be paid at the time of service. Please let us know if you need more information.

*\* Your email address is requested for the sole purpose of facilitating communications with your provider through our HIPAA-compliant Patient Portal.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if patient is a minor)

For NCK staff: \_\_\_\_\_