



Christopher M. Boxell, M.D.  
Neurosurgeon

SouthCreek Medical Plaza  
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## Patient Registration

Patient											
Patient's Last Name		First Name (Full Legal)			Middle Name		Nickname		Maiden/Previous Name		
Address				City		State		Zip		Marital Status (Circle) Married    Single    Divorced    Separated    Widowed	
Age	Date of Birth	Sex (Please Circle) Male/Female	Social Security Number			Home Phone (    )		Cell Phone			
Employer			Occupation			Patient's E-mail Address					
Employer's Address				City		State		Zip		Business Phone	
Spouse's Last Name			First Name			Spouse's Social Security No.			Spouse's Cell Phone		
Spouse's Employer			Business Phone		Emergency Contact Name			Emergency Contact Phone No.			
What Doctor referred you to our office?					Primary Care Physician						

Person Responsible for Bill other than Patient											
Responsible Party's Last Name		First Name			Middle Initial		Relation		Home Phone		
Address				City		State		Zip		Business Phone    Extension	
Employer			Occupation			Length of Employment		Cell Phone			
Employer's Address				City		State		Zip		Social Security No.	

Insurance									
Primary Insurance Company			Policy Holder's Name (From Card)			Policy No.		Group No.	
Policy Holders Social Security No.			Date of Birth	Employer Name					
Secondary Insurance Company			Policy Holder's Name (From Card)			Policy No.		Group No.	
Policy Holders Social Security No.			Date of Birth	Employer Name					

Is this Worker's Compensation? Auto Accident? or Personal Injury? (Circle)									
Claim Number		Coverage By				Business Phone		Extension	
Address					Adjuster			Fax Number	
Date of Injury	Date Last Worked		Are you on Light Duty?		Explain your tasks:				
Attorney Name		Phone Name			Address				

I have reviewed a copy of the notice of Privacy Practices Act.

\_\_\_\_\_  
Patient's or Responsible Party Signature

\_\_\_\_\_  
Date Signed

### Assignment of Insurance Benefits

I agree that insurance benefits for Dr. Boxell charges payable to the insured are to be made payable to Dr. Chris Boxell and that the physician benefits otherwise payable to the injured are to be made payable to the physician responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

\_\_\_\_\_  
Patient's or Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date Signed