



RAJIV M. JOSEPH, M.D., Ph.D., F.A.A.N.

NEUROLOGY & SLEEP MEDICINE

www.DallasNeurology.com • www.SleepDisordersClinic.com

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REGISTRATION

PATIENT INFORMATION

Name _____ Soc. Sec # _____
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____
Primary Care Physician _____ Phone _____
In case of emergency who should be notified? _____ Phone _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone # _____ Fax # _____
Address: _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (If different from patient's) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____ Policy # _____ Group# _____

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? Yes No
Subscriber Name _____ Relationship to Patient _____ Birthdate _____
Address (If different from patient's) _____
Insurance Company _____ Policy # _____ Group# _____

ASSIGNMENT AND RELEASE

I hereby assign all medical benefits including major benefits to which I am entitled for medical services rendered to myself or my dependents, to Rajiv Joseph, M.D., P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment on my behalf.

Signature of Patient or Parent if Minor Relationship
Date _____