PATIENT INFORMATION SHEET

Please write legibly

DATE________________________

PATIENT NAME____ DATE OF BIRTH_______________

AGE ___ SEX ___ M ___ F SOCIAL SECURITY # ____-_____-_____ MARITAL STATUS_____________

ADDRESS______________________________________CITY_____________STATE____ZIP________

HOME TELEPHONE (   )____________ WORK (   ) _________________ CELL (   ) _______________

EMPLOYER __________________________________ OCCUPATION ___________________________

EMPLOYER'S ADDRESS ___________________________________ CITY/STATE_________________

LEGAL GUARDIAN/PARENT/SPOUSE'S NAME______________________RELATIONSHIP__________

ADDRESS____CITY/STATE/ZIP______________________

SPOUSE'S EMPLOYER______________________________BUSINESS PHONE (   ) _______________

EMERGENCY CONTACT ________________RELATIONSHIP__________PHONE# (   )_____________

REFERRING PHYSICIAN_________________________________ PHONE# (   ) ___________________

OTHER DOCTORS YOU SEE REGULARLY ____

HOW DID YOU HEAR ABOUT US? ____

INSURANCE INFORMATION

THIS SECTION MUST BE COMPLETED EVEN IF A COPY OF YOUR CARD IS PROVIDED

IS THIS A WORKERS COMPENSATION CASE?___ IF YES, NOTIFY RECEPTIONIST IMMEDIATELY!!

DO YOU HAVE LONG-TERM INSURANCE? _____ INSURANCE COMPANY_____________________

PRIMARY INSURANCE COMPANY NAME:____

POLICY/ID#:___________________________________GROUP#:_______________________________

POLICY HOLDER NAME:________________________RELATION TO PATIENT___________________

POLICY HOLDER SS#______-_________-________ POLICY HOLDER D.O.B.______________________

SECONDARY INSURANCE COMPANY NAME:____

POLICY/ID# _____________________________________GROUP#_____________________________

POLICY HOLDER NAME________________________RELATION TO PATIENT___________________

POLICY HOLDER SS#_____-_______-______ POLICY HOLDER D.O.B.___________________________

AUTHORIZATION:
I hereby authorize Clinical Neurology, PC to release any information requested with respect to insurance claims and bills as the provider of the service rendered. I also authorize payment of insurance benefits directly to Clinical Neurology, P.C.

_____________________________________   ____

Date   Signature of Patient/Parent/Guardian

SHOULD THIS BILL CREATE FINANCIAL HARDSHIP, PLEASE DISCUSS THIS WITH US IMMEDIATELY