PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
First Middle Last

Home Address: _____ City: _____ State: _____ Zip:_____

Mailing Address: _____ City: _____ State: _____ Zip:_____

Telephone: ( ) _____ Date of Birth: _____ Age: _____

Occupation: _____ Social Security No.: _____

Employer: _____ Home Phone: ( ) _____

Cell: ( ) _____ Work Phone: ( ) _____

Family Doctor: _____ Family Doctor Phone: ( ) _____

Requesting Doctor: _____ Requesting Doctor Phone: ( ) _____

Pharmacy Name: _____ Pharmacy Phone: _____

Race (Check One):
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Island
☐ Black or African American ☐ White ☐ Unspecified
☐ Decline to State ☐ Some Other Race

Ethnicity (Check One):
☐ Unspecified ☐ Decline to State ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Preferred Language (please state): _____

****

Name of Spouse: _____ Telephone: ( ) _____

In Case of an Emergency, Contact: _____ Relation to Patient: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

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Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Date of Birth: _____ Social Security No.:_____

Employer: _____ Telephone ( ) _____

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INSURANCE INFORMATION

PRIMARY

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Group #: _____

Policy I.D. Number: _____ Insured's Social Security Number: _____

Insurance Company's Phone: ( )_____

Patient's Name: _____ Today's Date: _____

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SECONDARY

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Group #: _____

Policy I.D. Number: _____ Insured's Social Security Number: _____

Insurance Company's Phone: ( )_____

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INJURIES AND ACCIDENTS

Please Check One:

Were you injured at Work? ☐ Yes ☐ No In an Auto Accident? ☐ Yes ☐ No Personal Injury? ☐ Yes ☐ No

Name of Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____ Date of Injury: _____

Is an attorney involved? (Check One): Yes No Attorney's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Adjuster's Phone: ( ) _____

All HMO'S, IPA'S REQUIRE PRIOR AUTHORIZATION (REFERRALS) FOR EACH OFFICE VISIT. THIS IS THE PATIENT'S RESPONSIBILITY. IF NEUROSURGICAL CONSULTANTS, INC. DOES NOT RECEIVE THE AUTHORIZATION; I UNDERSTAND THAT PAYMENT WILL BE THE PATIENT'S (PARENT OR GUARDIAN IF MINOR) RESPONSIBILITY.

I HEREBY AUTHORIZE PAYMENT BE MADE DIRECTLY TO NEUROSURGICAL CONSULTANTS, INC., FOR SERVICES PROVIDED TO ME IN THE COURSE OF MY MEDICAL CARE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. IF ANY COLLECTION ACTIVITIES ARE COMMENCED REGARDING MY UNPAID BALANCE, I AGREE TO BE RESPONSIBLE FOR ALL COST'S AND ATTORNEYS FEES ASSOCIATED THEREWITH. I FURTHER UNDERSTAND THAT 1.5% PER MONTH INTEREST WILL BE ACCRUED ON ANY OUTSTANDING BALANCES OVER 60 DAYS.

_____ **Date:** _____

Patient or Guardian Signature

Form Creation Date: March 29, 2011