

PATIENT INFORMATION

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

Home Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Birthdate: _____ Age: _____

Occupation: _____ Social Security No.: _____

Employer: _____ Telephone No. () _____

Family Doctor: _____ Address: _____

Requesting Doctor: _____ Address: _____

Pharmacy Name: _____ Phone: _____

Name of Spouse: _____ Birthdate: _____

Occupation: _____ Social Security No.: _____

Employer: _____ Telephone: () _____

In Case of an Emergency, Contact: _____ Relationship _____

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

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

Responsible Party: _____ Relation to Patient: _____

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

Telephone: () _____ Birthdate: _____ Social Security No. _____

Employer: _____ Telephone () _____

INSURANCE INFORMATION

[PRIMARY]

Name and Address of Insurance Co.: _____

City: _____ State _____ Zip: _____

Insured's Name: _____ Group #: _____

Policy I.D. # _____ Insured's Social Security No. _____

Insurance Company's Phone No. : () _____

INSURANCE INFORMATION (CONTINUED)

Patient Name: _____ Today's Date: _____

[SECONDARY]

Name and Address of Insurance Co. _____

City: _____ State: _____ Zip: _____

Insured's Name _____

Group #: _____ Policy I.D. #: _____

Insured's Social Security No.: _____

[INJURIES AND ACCIDENTS] Please circle one:

Were you injured at Work? yes no In an Auto Accident? yes no Personal Injury? yes no

Date of Injury: _____ Name and Address of Ins. Co.: _____

Claim #: _____ Is an attorney involved? yes no

[Attorney's]

Name: _____ Address _____

City: _____ State _____ Zip: _____

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.

Patient or Guardian Signature **Date:** _____