CONFIDENTIAL INFORMATION

PLEASE PRINT clearly - SIGNATURE required

TODAY'S DATE_____ (FOR OFFICE USE ONLY) #_____

PATIENT NAME:_____ _____ _____
First Middle Last

SOC SEC _____-_____-_____ SEX_____ BIRTHDATE_____-_____-_____MARITAL STATUS M S W D

ADDRESS_____ APT #_____HOME PHONE ( )_____

CITY /STATE_____ ZIP_____CELL PHONE ( )_____

EMAIL ADDRESS_____RACE_____

ETHNICITY (PLEASE CIRCLE) HISPANIC/LATINO OR NON HISPANIC/LATINO PREFERRED LANGUAGE_____

EMPLOYER NAME_____WORK PHONE ( )_____EXT_____

EMPLOYER ADDRESS_____

INSURANCE COMPANY NAME_____INSURED NAME_____

RELATIONSHIP TO PATIENT_____INSURED DATE OF BIRTH_____

INSURED ID #_____GROUP #_____

FAMILY PHYSICIAN_____ PHONE (_____)_____

REFERRED HERE BY_____

PHARMACY NAME_____ADDRESS_____PHONE ( )_____

IN EMERGENCY, NOTIFY

NAME_____RELATIONSHIP_____PHONE ( )_____

RESPONSIBLE PERSON (Responsible for billing)

NAME_____ HOME PHONE ( )_____

ADDRESS_____ WORK PHONE ( )_____

CITY/STATE/ZIP_____ RELATIONSHIP TO PATIENT_____

SOC SEC #_____ DATE OF BIRTH_____

EMPLOYER/ADDRESS _____CITY/STATE/ZIP_____

SPOUSE NAME_____SPOUSE SOC SEC# _____

EMPLOYER/ADDRESS_____

RELEASE OF INFORMATION AND BENEFITS STATEMENT FOR SIGNATURE

I authorize the release of medical information necessary to process my insurance claim. I understand these records may include psychological or psychiatric impairments, drug abuse, alcohol abuse, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS) or test results for HIV.

I authorize payment of insurance benefits (basic, major medical, HMO, PPO, Medicare or Medicaid) to the undersigned physician or supplier for the services described on the attached claim.

I acknowledge that I am responsible for payment of fees assessed for appointments not kept or canceled with less than a 24-hour notice.

I have been informed that the privacy policy of Memorial Neurological Association as it pertains to my health information is posted in the waiting room and a copy is available to me upon request.

DATE SIGNED _____ SIGNATURE_____

pd: patient information 5-2007; rev. 6-2007 ll; rev. 10-2009 ks; rev. 8-2011 ks; rev. 11-2011