

PATIENT INFORMATION

(PLEASE PRINT)

NAME _____ M _____ F _____ AGE _____

BIRTHDATE _____ SOCIAL SECURITY _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

REFERRED BY _____ PRIMARY CARE DR. _____

PRIMARY INSURANCE CO. _____

INSURED/POLICY HOLDER NAME _____ BIRTHDATE _____

SOCIAL SECURITY # _____ EMPLOYER _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE CO. _____

INSURED/POLICY HOLDER NAME _____ BIRTHDATE _____

SOCIAL SECURITY # _____ EMPLOYER _____

RELATIONSHIP TO PATIENT _____

DOES YOUR PRIMARY INSURANCE COMPANY AUTOMATICALLY BILL YOUR SECONDARY INSURANCE COMPANY? YES _____ NO _____

I hereby authorize my insurance benefits to be paid directly to Four Peaks Neurology, P.C. I am aware I am financially responsible for non-covered services and/or my portion of the fees required by my insurance company. If a referral is required and not available at the time of your appointment, you will be responsible for the office visit fee. I also authorize the release of any information that is required to secure payment of services rendered.

PATIENT'S SIGNATURE _____ DATE _____

I hereby authorize Four Peaks Neurology to leave messages containing medical information on voice mail/answering machine or mail.

Agree _____ Disagree _____ Phone # _____

Address _____

PATIENT'S SIGNATURE _____ DATE _____