NEW PATIENT INFORMATION

PLEASE PRINT

PLEASE COMPLETE AND BRING THIS FORM WITH YOU TO THE APPOINTMENT.
******* DO NOT MAIL*******

WELCOME TO OUR OFFICE

DATE ____________________

PATIENT'S NAME	S.S. #	SEX	MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE

STREET ADDRESS	CITY & STATE	ZIP CODE	HOME PHONE #

PATIENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUS. PHONE #

EMPLOYER'S ADDRESS	CITY & STATE	ZIP CODE	ALTERNATE/EMERGENCY PHONE #	NAME & RELATION TO PT.

SPOUSE OR PARENT'S NAME	S.S. #

SPOUSE OR PARENTS EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUS. PHONE #

EMPLOYER'S ADDRESS	CITY & STATE	ZIP CODE

IF BOTH PARENTS WORK:

OTHER EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUS. PHONE #

EMPLOYER'S ADDRESS	CITY & STATE	ZIP CODE	HOME PHONE #

PLEASE HAVE YOUR INSURANCE CARDS AVAILABLE.

NAME OF PRIMARY INSURANCE	INSURED'S BIRTHDATE	POLICY #	GROUP #
NAME OF SECONDARY INSURANCE	INSURED'S BIRTHDATE	POLICY #	GROUP #

MEDICAID	EFFECTIVE DATE	COUNTY	BILLING #

☐ WORKMEN'S COMPENSATION	DATE OF INJURY	INDUSTRIAL CLAIM #

EMPLOYER AT TIME OF INJURY	PHYSICIAN OF RECORD

☐ ACCIDENT	WAS AN AUTOMOBILE INVOLVED?	☐ YES ☐ NO	DATE OF ACCIDENT

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIANS BEFORE?

REFERRED BY	ADDRESS, CITY, STATE	ZIP CODE	PHONE #

MEDICATION ALLERGIES ☐ NO ☐ YES: IF YES, PLEASE LIST

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS AND PRE-ADMISSION CERTIFICATION INFORMATION PRIOR TO HOSPITALIZATION.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH YOUR PATIENT ACCOUNT REPRESENTATIVE.

SIGNATURES NEEDED ON BACK OF FORM

CONSENT TO TREATMENT:

I hereby give consent to NeuroCare Center, Inc., its personnel, and to my physicians to perform or administer such procedures, examinations, treatments, diagnostic and therapeutic drugs and medications as may be necessary to treat the injury or illness of the below named patient.

X ____

(Signature of Patient or Legal Guardian)

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I request that payment of benefits be made on my behalf to NeuroCare Center, Inc. For any services furnished me by their physicians. I authorize release to the health care financing administration and/or insurance carriers any medical information about me needed to determine these payments for related services.

________________ X ____

(Date) (Signature of Patient or Legal Guardian)

CONSENT TO DISCLOSURE/RELEASE OF MEDICAL RECORDS:

I further consent to the disclosure of medical information about me to the (1) employees, agents, and independent contractors of NeuroCare Center, Inc. as may be necessary or appropriate in connection with their performance of billing-related or other clerical tasks for or on behalf of NeuroCare Center, Inc.; (2) my own physician or physicians; (3) third parties assisting in providing care to me; (4) record technicians acting on behalf of NeuroCare Center, Inc.; (5) attorneys, my attending and other physicians. Authorization supplies to all or part of these records including treatment for physical, mental, HIV, and/or alcohol and drug abuse.

________________ X ____

(Date) (Signature of Patient or Legal Guardian)