

PATIENT INFORMATION

CHART

Patient Name		Age	Birth date	Sex	SS#
Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D		Address			City, State, Zip
Home Telephone		Work Telephone		Cellular Telephone	
Employer Name	Employer Address			City, State, Zip	
Occupation (indicate if student)					
Name of Person Responsible for Payment		SS#	Relationship	Home telephone Work telephone	
Address				City, State, Zip	
Employer of Person Responsible					
In case of emergency contact				Telephone	

HEALTH INSURANCE INFORMATION

Name of Primary Insurance Company			SS#
Name of Policyholder	Relationship	Date of Birth	
Secondary Insurance			Telephone
Date of Injury			
Referring Physician	Telephone	Address	City, State, Zip

All professional services rendered are charged to the patient. Necessary forms will be completed by the Neurosurgical Consultants, PA staff in order to expedite insurance carrier payments. I understand that I am responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance Authorization and Assignment (Please read and sign)

I hereby authorize Neurosurgical Consultants, P.A. to furnish information to insurance carriers and to other doctors involved in my care concerning my illness and treatments, and I hereby assign to Neurosurgical Consultants, P.A. all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature

Date