Neurology& Neurodiagnostics

Referred by: ☐ Yellow Pages ☐ Other (List name of doctor, friend, etc.)				
PATIENT'S NAME M__ F__	SOCIAL SECURITY #	MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE
STREET ADDRESS	CITY, STATE, ZIP CODE		HOME PHONE #	
P.O. BOX	CITY, STATE, ZIP CODE		CELL PHONE #	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG	E-MAIL	
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE		BUS. PHONE #	
DRUG ALLERGIES IF ANY				
SPOUSE OR PARENT'S NAME	SOCIAL SECURITY #	NUMBER OF CHILDREN AND AGES		
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG	BUS. PHONE #	
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE			
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP			
ADDRESS, CITY, STATE, ZIP CODE	PHONE #			

INSURANCE INFORMATION

(INCLUDE MEDICARE, MEDICARE SUPPLEMENT, PRIVATE, GROUP AND SPOUSE)

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE, ZIP CODE	PHONE #
(1) INSURANCE COMPANY NAME	SPOUSE _____ SELF _____ OTHER _____	
(2) INSURANCE COMPANY NAME	SPOUSE _____ SELF _____ OTHER _____	
SPECIAL NOTES:		

May we call you at work regarding lab or other test results? _____

Please indicate the name and phone # of **your preferred Pharmacy**_____**PH**_____

Advanced Directive: All adults in health care settings in the state of Florida have the right to an "advanced directive." This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An advanced directive enables you to state your choice or name someone to make your choice for you, if you should become unable to make decisions about your medical treatment. An advanced directive can enable you to make decisions. Do you have a Living Will? ☐ Yes ☐ No (if yes, please provide the office with a copy.)

I authorize the release of medical information necessary to obtain payment of medical benefits from my health insurance company. I also authorize my insurance company to pay Doctor any medical benefits due for services rendered. I understand that I am responsible to pay deductibles, co-pays, and any other charges not paid by my insurance company. CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT.

Our policy is that payment is expected in full at the time services are rendered, unless other financial arrangements are made in advance. If you participate with one of our contracted insurance programs, we will bill your insurance company. Verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary.

Due to the high demand for medical appointments we have had to institute a policy of charging for missed appointments or those cancelled less than 24 hours in advance. All "no shows" and late cancellations will be billed $20.00.

To the best if my knowledge the above information is correct. I understand and agree to comply with the practice's financial policy.

Signature: _____**Date:**_____

Print Name: _____