NEUROLOGICAL ASSOCIATES of NEVADA

☐ **New patient** ☐ **Established patient** **Date:**

PATIENT INFORMATION

PATIENT NAME (LAST) _____ (FIRST)_____ (M.I.) _____

SSN: _____-_____-_____ SEX: _____ AGE: _____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

MARITAL STATUS: _____ DATE OF BIRTH: _____ - _____ - _____

ADDRESS: _____ APT # _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT'S EMPLOYER (Guarantor if patient is a minor) _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ WORK #: _____

CITY: _____ STATE: _____ ZIP: _____

GUARANTOR INFORMATION

GUARANTOR NAME (LAST) _____(FIRST) _____ (M.I.) _____

GUARNATOR ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

GUARANTOR EMPLOYER: _____ OCCUPATION:_____ WORK #: _____

GUARANTOR EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REFERRAL INFORMATION

REASON FOR VISIT: _____ REFERRING PHYSICIAN: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY CONTACTS

WHO DO WE NOTIFY IN CASE OF EMERGENCY? _____ PHONE ( )_____

RELATIONSHIP: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION (please have receptionist copy your insurance cards)

PRIMARY INSURANCE CO: _____ PHONE ( )_____

ADDRESS: _____STATE: _____ ZIP: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____ SSN: _____-_____-_____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER'S EMPLOYER: _____

POLICY #: _____ GROUP #: _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE CO: _____ PHONE ( )_____

ADDRESS: _____STATE: _____ ZIP: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____ SSN: _____-_____-_____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER'S EMPLOYER: _____

POLICY #: _____ GROUP #: _____ EFFECTIVE DATE: _____

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. in the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor. A copy of the signature is as valid as the original.

_____ _____ _____ _____

_____

PATIENT SIGNATURE **DATE** **GUARANTOR SIGNATURE** **DATE** **REGISTERED BY INITIALS**