Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print.
All information will be confidential.

Todays Date:_______________Patient Name:____(Male/Female)

***Ethnicity- Hispanic Not Hispanic**
***Race - White African American Asian Pacific Islander Amer Indian/Alaskan Other**

Address:____
(Street) (City) (State) (Zip Code)

Phone#____________________________Date of Birth_____/_____/_____SSN#_________________________

Cell Phone#_________________________ **Preferred Communication**: Phone Mail Text E-mail______________________

Employer:____Phone#________________________________

Referring Physician:____Phone#_________________________

Pharmacy Name:__________________________ Phone #_______________________

WE ARE ONLY PARTICIPATING WITH BASIC MEDICARE & MULTIPLAN

Primary Insurance

Insurance Co.____ID#____________________________________

Policy Holder: (Self / Spouse / Other) Group#_________________________Phone#_______________________________________

Policy Holder's Name:__________________________ **DOB**:_______________________ **SS#**:______________________________

Secondary Insurance

Insurance Co.____ID#____________________________________

Policy Holder: (Self / Spouse / Other) Group#_________________________Phone#_______________________________________

Policy Holder's Name:___________________________**DOB**:________________________**SS#**:______________________________

If this appointment is related to an injury, please provider the information requested below in the appropriate category.

Worker's Compensation__________________Insurance Company____
Date of Injury Name Phone#
Claim#_____________________ **Employer Name**:___________________________________ **Phone#**_________________________

Motor Vehicle Accident__________________Insurance Company____
Date of Injury Name Phone#
Claim #_____________________**Adjusters Name**:__________________________________**Phone#**_________________________

Other Liability _________________________Adjuster/Claim Manager____
Date of Injury Name Phone#
Claim #_____________________

Attorney____
Name Address Phone#

Authorization and Release: I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to **Neurosurgical Consultants of South FL**

Signature:____**Date:**________________________