PATIENT INFORMATION

Patient Name ______________________________ Today's Date ____/____/____

Address ______________________________ Former Name ______________

City ______________________ State ________ Zip ____________

Home Phone ( ) ____________ Mobile Phone ( ) ____________ Work Phone: ( ) ____________

Social Security # ______________ Birth Date ____/____/____

Email Address: ______________________ Marital Status: (check one) ❑ M ❑ S ❑ D ❑ W

Employer ______________________________

Referring Physician ______________________________

Referring Dr. Address ______________________ Phone ( ) ____________

Primary Dr. ______________________________

Primary Dr. Address ______________________ Phone ( ) ____________

Primary Insurance Co. ______________________________

ID # ______________________ Group # ____________

Subscriber ______________ Birthdate ____/____/____ Relationship to Insured ____________

Secondary Insurance Co. ______________________________

ID # ______________________ Group # ____________

Subscriber ______________ Birthdate ____/____/____ Relationship to Insured ____________

HEALTH INSURANCE/MEDICARE AUTHORIZATION: I authorize the release of any information necessary to process claims on my behalf to Medicare and all other health insurance companies of which I am a beneficiary, and payment of said claims directly to Meadowbrook Neurology Group, P.C.

Signature: Date ____/____/____

EMERGENCY CONTACT: In the event of emergency, or if you would like us to discuss your Protected Health Information with a friend or family member, you must provide us with authorization to do so.

You may release my Protected Health Information to: ______________________
Name of Friend/Relative

Emergency Contact Phone: ______________________

Relationship to Patient ❑ Spouse ❑ Child ❑ Friend ❑ Other ____________

Signature: Date ____/____/____

PLEASE COMPLETE PAGE 2 (REVERSE SIDE) OF THIS FORM. THANK YOU.

Revised 12/22/2010

RACE, ETHNICITY & PREFERRED LANGUAGE

Please check one selection in each category. We ask these questions to satisfy government requirements. If you object to these questions, you may decline to answer.

Race:
- ❑ American Indian or Alaska Native
- ❑ Black or African American
- ❑ Other Race
- ❑ Asian
- ❑ White
- ❑ Other Pacific Islander
- ❑ Native Hawaiian
- ❑ Hispanic
- ❑ Unreported/Declined to Report

Ethnicity: ❑ Hispanic ❑ Non Hispanic ❑ Unreported/Declined to Report

Preferred Language ❑ English ❑ Spanish ❑ Russian ❑ Indian (includes Hindi & Tamil) ❑ Other

PHARMACY INFORMATION

Local Pharmacy

Name of Pharmacy ______________________________

Address ______________________________

Mail Order Pharmacy

Name of Pharmacy ______________________________

Address ______________________________

LABORATORY INFORMATION

Which laboratory do you typically use?

❑ Quest Diagnostics ❑ LabCorp ❑ Primary Care Physician's Office

❑ Other Name of Lab ______________________________

ACCIDENT INFORMATION

To be completed only if your visit is related to an accident.

❑ AUTO ❑ WORK ❑ CLAIM OPEN VERIFIED WITH ______________________________

Date of Accident ____/____/____ Claim # ______________________________

Place of Accident ______________________________

Insurance Carrier ______________________________

Address ______________________________

Adjuster Name ______________________________ Adjuster Phone ( ) ______________

Attorney Name ______________________________ Attorney Phone ( ) ______________

Attorney Address ______________________________

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