Neurological Specialties

**PLEASE COMPLETE ALL AREAS ON FORM THANKYOU**

2816 W. Virginia Avenue Tampa, FL 33607

(813) 876-6321

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| **TODAY’S DATE**  **PATIENT INFORMATION** - PLEASE PRINT | | | | |
| **LAST NAME** **FIRST NAME** | | | **CELL PHONE** | **WORK PHONE/EXT.** |
| **STREET ADDRESS CITY STATE ZIP** | | | **DATE OF BIRTH** | **SOCIAL SECURITY #** |
| **PHARMACY ADDRESS ZIP CODE TELEPHONE # SEX (circle one) MARITAL STATUS (circle one)**  **M F S M w DIV SEP** | | | | |
| **EMPLOYER NAME ADDRESS OCCUPATION** | | | | |
| **FAMILY PHYSICIAN REFERRING PHYSICIAN** | | | | |
| **SPOUSE** / **PARENT** - PLEASE COMPLETE | | | | |
| **LAST NAME FIRST NAME** | | | **CELL PHONE** | **WORK PHONE/EXT.** |
| **STREET ADDRESS CITY STATE ZIP** | | | **DATE OF BIRTH** | **SOCIAL SECURITY #** |
| **RELATIONSHIP TO PATIENT** | | | | |
| **INSURANCE INFORMATION** | | | | |  |
| **PRIMARY HEALTH OR AUTO INSURANCE** | **SECONDARY INSURANCE** | | | |
| **INSURANCE COMPANY PHONE** | **INSURANCE COMPANY PHONE** | | | |
| **ADDRESS** | **ADDRESS** | | | |
| **CITY/STATE/ZIP** | **CITY/STATE/ZIP** | | | |
| **I.D.NUMBER CLAIM NUMBER** | **I.D.NUMBER CLAIM NUMBER** | | | |
| **GROUP NAME OR NUMBER** | **GROUP NAME OR NUMBER** | | | |
| **Guarantor’s LAST NAME FIRST NAME** | **Guarantor’s LAST NAME FIRST** **NAME** | | | |
| **Guarantor’s Date of Birth** | **Guarantor’s Date of Birth** | | | |
| **RELATIONSHIP TO GUARANTOR (CIRCE ONE) EMPLOYER INS (CIRCE ONE)**  **SELF SPOUSE PARENT CHILD** **YES NO** | **RELATIONSHIP TO GUARANTOR (CIRCE ONE) EMPLOYER INS (CIRCE ONE)**  **SELF SPOUSE PARENT CHILD**  **YES NO** | | | |
| **EMERGENCY CONTACT** - **OTHER THAN YOUR SPOUSE** | | | | |
| **NAME** | **RELATIONSHIP PHONE** | | | |
| **STREET** **ADDRESS** | **CITY/STATE/ZIP** | | | |
| **PAYMENT AGREEMENT** | | | | |
| I understand that I am ultimately responsible for charges incurred for service and not covered by insurance or third party. In the absence of participating third party coverage, payment in full is due at the time of service. For insurance plans in which my treating physician | | | | |
| participates, non-covered services, applicable copay and/or unmet deductible are due at time  of service. I request payment and assign benefits of government, contracted entities, and third-party payor benefits to Neurological Specialties. | |  | | |
| **PATIENT/ RESPONSIBLE PARTY SIGNATURE DATE** | | |
| **CONSENT FOR TREATMENT/ INFORMATION RELEASE** | | | | |
| I hereby give consent to Neurological Specialties to provide whatever treatment they may deem necessary to the above-named patient. I authorize Neurological Specialties and staff to release any medical or other information necessary to process medical insurance and to provide for continuity of care. | | | | |
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| **PATIENT/ RESPONSIBLE PARTY SIGNATURE DATE** | | |

