Neurological Specialties

2816 W. Virginia Avenue
Tampa, FL 33607
(813) 876-6321

PLEASE COMPLETE ALL AREAS ON FORM
THANK YOU

PATIENT INFORMATION - PLEASE PRINT

LAST NAME	FIRST NAME	M.I.	HOME PHONE	CELL PHONE	TODAY'S DATE

STREET ADDRESS	DATE OF BIRTH	AGE	SOCIAL SECURITY #	WORK PHONE/EXT.

CITY	STATE	ZIP	SEX	MARITAL STATUS	DRIVER'S LICENSE #
			☐M ☐F	☐S ☐M ☐W ☐DIV ☐SEP	

EMPLOYER NAME	ADDRESS	OCCUPATION

SPOUSE / PARENT - PLEASE COMPLETE

LAST NAME	FIRST NAME	M.I.	HOME PHONE	WORK PHONE/EXT.

STREET ADDRESS	DATE OF BIRTH	AGE	SOCIAL SECURITY #

CITY	STATE	ZIP	SEX	DRIVER'S LICENSE #
			☐M ☐F	

EMPLOYER NAME	ADDRESS	OCCUPATION

FAMILY PHYSICIAN	REFERRING PHYSICIAN

INSURANCE INFORMATION - PLEASE COMPLETE

PRIMARY HEALTH OR AUTO INSURANCE		SECONDARY INSURANCE	
INSURANCE COMPANY	PHONE	INSURANCE COMPANY	PHONE
ADDRESS		ADDRESS	
CITY/STATE/ZIP		CITY/STATE/ZIP	
I.D. NUMBER		I.D. NUMBER	CLAIM NUMBER
GROUP NAME OR NU		GROUP NAME	
INSURED'S LAST NAME	ST NAME	INSURED'S LAST	FIRST NAME
ADDRESS		ADDRESS	
CITY/STATE/ZIP		CITY/STATE/ZIP	
RELATIONSHIP TO GUARANTOR ☐ SELF ☐ HUSBAND ☐ PARENT ☐ WIFE ☐ CHILD ☐ OTHER	EMPLOYER INS. PLAN YES ☐ NO ☐	RELATIONSHIP TO GUARANTOR ☐ SELF ☐ HUSBAND ☐ PARENT ☐ WIFE ☐ CHILD ☐ OTHER	EMPLOYER INS. PLAN YES ☐ NO ☐

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EMERGENCY INFORMATION - OTHER THAN YOUR SPOUSE

NAME	RELATIONSHIP	HOME PHONE	WORK 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.

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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 as necessary and to provide for continuity of care.

PATIENT / RESPONSIBLE PARTY SIGNATURE DATE