NEW PATIENT INFORMATION SHEET

WELCOME TO METROLINA NEUROLOGICAL ASSOCIATES, PA

PATIENT INFORMATION

4/10/2015

Title: Last Name: First Name: MI

Street Address: Apt:

Zip Code: City: State:

Home Phone: Cell Phone: Work Phone:
Email Address:
Social Security Number:

Birthday: Sex: Race: Primary Doctor:

Martial Status: Employment: Full___PT____ Student: Full___
Retired____ None_____ PT_____

Relationship to Insured: Self____ Spouse____Child____Other
EMPLOYER:
ADDRESS AND PHONE NUMBER:

Nearest Friend or Relative Not Residing with Patient/Relationship:
Address and Phone Number:

Minor Name of Parent or Guardian:

INSURANCE INFORMATION/WORKERS COMPENSATION

Primary Insurance Company Name: Address: Insured:
Insured DOB: Telephone Number: Policy Number:
Group Number: Effective Date:
Secondary Insurance Company Name: Address: Insured:
Insured DOB: Telephone Number: Policy Number:
Group Number: Effective Date:
Workers Compensation: Name of Carrier and Address:
Telephone Number and Contact Person: Name of Employer:
Employers Address and Telephone Number: Date of Injury:

I authorize the release of any medical information necessary to process insurance claims. I request payment of benefits either to myself or the party who accepts assignment. I understand that I am financially responsible for payment or charges not covered by this authorization. I voluntarily consent to treatment at this facility from physicians and staff. No guarantees have been made to me about the results or treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and have had the opportunity to ask questions.

_____Patient or Guardian _____Date