Coastal Neurology, PA

PATIENT INFORMATION

Name:	**Birth Date:** **Marital Status: S M Sep D W**
Mailing Address:	**Social Security #:**
Address:	**Sex: F M** **Race:** **Language:**
City:	**E Mail:**
State: **Zip:**	**Emergency Contact:**
Home Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
May we leave Voice Mails? Yes No	**Messages on Answering Machine? Yes No**
Work Phone#:	**Student: Yes No Part Time Full Time**
Employer:	**Work Status: FT PT RET SELF AD Mil OTHER**
Employer Address:	**Job Related?: Yes No**
City: **State:** **Zip:**	**Accident Related?: Yes No**
Date of Injury/Accident: **Type of Injury/Accident:**	**Adjusters Name/Phone:**
Referring Doctor:	**Primary Care Doctor:**

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address:	**Social Security#:**
Address:	**Relationship:**
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Cell Phone#:	**Employer State:** **Zip:**
	Employer Phone:

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
ID#:	**ID#:**
Group #:	**Group #:**
Group Name:	**Group Name:**
Copay:	**Copay:**
Subscriber Name:	**Subscriber Name:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to Coastal Neurology when they accept assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Coastal Neurology, to release any information necessary for my course of treatment.

Responsibility: All professional services are the responsibility of the patient/guarantor. The patient/guarantor is responsible for any and all collection fees, attorney charges and court costs. A finance/billing fee may apply to delinquent balances. Coastal Neurology maintains the right to refuse treatment to any non-emergent patient.

_____ _____

Signature (patient or guarantor) Date

_____ _____

Name Relationship