COASTAL NEUROLOGY
NEW PATIENT INFORMATION

Patient's Name	SS#	Birth Date	Age
Address	City/State/Zip Code	Home Phone #	Email
Marital Status Sex S /M / W / D / Sep	Emergency Contact/ Phone#		Race
Patient's Employer	Occupation	Work Phone #	FT or PT?
Employer's Address	City/State/Zip Code		How Long?
Spouse / Parents' Name	SS #	Birth Date	
Spouse or Parents' Employer	Occupation	Work Phone #	FT or PT?
Employer's Address	City/State/Zip Code		How Long?

PLEASE READ: All charges due at the time of service unless other arrangements were made. It is your responsibility to provide insurance information. Please provide the receptionist with your insurance card(s). THANK YOU

Person Responsible for Payment	Relationship	SSN#	Birth Date
Complete Address and Phone # if different from above			
Primary Insurance	Name of Insured (As shown on card)	ID#	
Primary Insurance Address & Phone #		Group#	
Secondary Insurance (If applicable)	Name of Insured (As shown on card)	ID#	
Secondary Insurance Address & Phone #		Group#	

Job Related Injury? Y / N	Date of Injury	Claims Adjuster's Name	Adjuster's Phone #
Accident Related? Y / N	Date of Accident	Type of Accident	
Were X-Rays Taken? Y / N	Date of X-Rays	Where?	Other Tests Performed?

If any member of your immediate family has been treated by our physician before, please list

Referring Doctor	Phone #	May we leave a message on your answering machine? Yes / No

All professional services are charged to the patient/guarantor. We will file insurance if previously agreed to. The patient/ guarantor is responsible for all collection fees, attorney charges and court costs. A finance charge may apply to delinquent balances.

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Coastal Neurology for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. We do not accept Medicaid as a secondary insurance.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it intermediaries or carriers any information needed for this or a related Medicare claim/other insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.

SIGNATURE _____ DATE _____