PATIENT INFORMATION - ADULT

_____ NEW PATIENT
_____ EMG/NCV
_____ EEG
_____ OTHER _____

REFERRED BY DR. _____

APPOINTMENT DATE _____
WITH DR. _____

PRIMARY CARE DR. _____

PATIENT _____ AGE _____ BIRTHDATE _____
First Name Middle Name Last Name

ADDRESS _____ PHONE ( ) _____
Number Street City State Zip

SOCIAL SECURITY NO. _____ DRIVERS LICENSE NO. _____ MARITAL STATUS ___

NAME OF EMPLOYER: _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE ( ) _____
Number Street City State Zip

NEUROLOGICAL PROBLEM _____

_____ DURATION _____

HAVE YOU MISSED ANY TIME FROM WORK DUE TO THIS ILLNESS OR INJURY? _____
IF YES, DISABILITY COMMENCED ON _____
IS NEUROLOGICAL PROBLEM DUE TO AN ACCIDENT? ___YES ___NO DATE OF ACCIDENT _____
IS NEUROLOGICAL PROBLEM DUE TO AN AUTO ACCIDENT? ___YES ___NO DATE OF ACCIDENT _____

SPOUSE NAME _____ SPOUSES SOCIAL SECURITY NO. _____

SPOUSE EMPLOYER _____ SPOUSE OCCUPATION _____

SPOUSE BUSINESS ADDRESS _____ BUSINESS PHONE ( ) _____

ALTERNATE CONTACT PERSON _____ RELATIONSHIP _____

ADDRESS _____ PHONE ( ) _____ BUS. PHONE ( ) _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ GROUP# _____

NAME OF INSURED _____ ID# _____

BILLING ADDRESS _____ PHONE ( ) _____

SECONDARY INSURANCE _____ GROUP # _____

NAME OF INSURED _____ ID# _____

BILLING ADDRESS _____ PHONE ( ) _____

INSURANCE INFORMATION

INSURANCE CARRIER _____ DARE OF INJURY _____ CLAIM # _____

BILLING ADDRESS _____ PHONE ( ) _____

ADJUSTER _____ DIRECT PHONE ( ) _____ AUTHORIZED BY _____

The above information is true to the best of my knowledge. I hereby authorize Leonard A. Gale, M.D., Paul C. Helfgott, M.D., Richard A. Rison, M.D., Gautam Ganguly, M.D., Nicholas N. Jonas, M.D., or Teresa Sokol, PA-C, to treat (me) the patient listed above. I authorize any physician, practitioner, hospital or insurance company to release to each other any medical information or other information acquired, including benefits paid or payable, concerning this or any other disabilities. In consideration of services rendered, I hereby irrevocably assign insurance benefits be paid directly to Neurology Consultants Medical Group.

SIGNATURE OF PATIENT _____ DATE _____