PATIENT INFORMATION - CHILD
APPOINTMENT DATE ________
WITH DR. ________________

_______ NEW PATIENT
_______ EEG
_______ OTHER

REFERRED BY DR. ____________
PRIMARY CARE DR. ____________

PATIENT (CHILD) ______________________________________ AGE ______ BIRTHDATE ______
First Name Middle Name Last Name

ADDRESS ____
Number Street City State Zip

SOCIAL SECURITY NO. (CHILD) ____________________ PHONE (   ) ____________

NEUROLOGICAL PROBLEM ____

____ DURATION ____________

MOTHER'S NAME ____
ADDRESS ______________________________ PHONE (   ) ____________
MOTHER EMPLOYED BY ______________________________ SS# ____________
BUSINESS ADDRESS ______________________________ BUSINESS PHONE (   ) ____________
MOTHER'S DRIVER LICENSE NUMBER ____________________ MOTHER'S BIRTHDAY ____________

FATHER'S NAME ____
ADDRESS ______________________________ PHONE (   ) ____________
FATHER EMPLOYED BY ______________________________ SS# ____________
BUSINESS ADDRESS ______________________________ BUSINESS PHONE (   ) ____________
FATHER'S DRIVER LICENSE NUMBER ____________________ FATHER'S BIRTHDAY ____________

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________________ GROUP# ____________

NAME OF INSURED ______________________________ ID# ____________

BILLING ADDRESS ______________________________ PHONE (   ) ____________

SECONDARY INSURANCE ______________________________ GROUP # ____________

NAME OF INSURED ______________________________ ID# ____________

BILLING ADDRESS ______________________________ PHONE (   ) ____________

Are the parents of this child divorced or separated?

In the case of divorced or separated parents, it is the policy of this office to collect payment from the parent or guardian who brings the child in for treatment.

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 the minor child 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 concerning the minor child listed above. In consideration of services rendered, I hereby irrevocably assign insurance benefits be paid directly to Neurology Consultants Medical Group. I further agree to be responsible for this child's medical expenses.

SIGNATURE OF PARENT OR GUARDIAN ____________________ DATE ____________