NEW PATIENT INFORMATION
NEUROLOGICAL SURGEONS OF DALLAS, P.A.

LAST NAME FIRST NAME MIDDLE NAME

ADDRESS/CITY/STATE/ZIP

F M **S M D W**

DATE OF BIRTH AGE GENDER MARITAL STATUS

DRIVER'S LICENSE/STATE SOCIAL SECURITY #

HOME PHONE WORK PHONE MOBILE PHONE

PATIENT'S EMPLOYER NAME **AND ADDRESS**

JOB DESCRIPTION/TITLE

SPOUSE NAME DRIVERS LICENSE

SPOUSE'S DATE OF BIRTH SPOUSE WORK PHONE

SPOUSE'S EMPLOYER

REFERRING DOCTOR

ADDRESS AND PHONE AND FAX NUMBER

EMERGENCY CONTACT OTHER THAN SPOUSE RELATIONSHIP

EMERGENCY CONTACT ADDRESS AND PHONE NUMBERS

PLEASE HAVE YOUR INSURANCE CARD WITH YOU FOR THIS APPOINTMENT

**PRIMARY INSURANCE COVERAGE

GROUP NUMBER ID NUMBER

PHONE NUMBER OF INSURANCE COMPANY CO-PAY

INITIAL AND DATE_______________________________

PPO HMO INDEMNITY NONE

INSURED NAME TYPE OF COVERAGE

REFERRAL NUMBER PCP NAME

PCP ADDRESS/CITY/STATE/ZIP PHONE FAX

**SECONDARY INSURANCE COVERAGE

GROUP NUMBER ID NUMBER

PHONE NUMBER OF INSURANCE COMPANY CO-PAY

INSURED NAME EMPLOYER

**SIGNATURE DATE

***IF YOU DO NOT HAVE SECONDARY INSURANCE COVERAGE PLEASE SIGN ABOVE

IS THIS WORK RELATED Y N DATE OF INJURY

CLAIM NUMBER ADJUSTOR

INSURANCE COMPANY + ADDRESS

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND NECESSARY INSURANCE FORMS WILL BE COMPLETED ON THEIR BEHALF TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL CO-PAYS AND DEDUCTIBLES. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. IN THE EVENT SURGERY IS PERFORMED, ANY FEES DUE FROM THE PATIENT WILL BE EXPECTED WHEN BILLED.

INSURANCE AUTHORIZATIONS AND ASSIGNMENT (PLEASE READ AND SIGN) I HEREBY AUATHORIZE Neurological Surgeons of Dallas TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

I AUTHORIZE MY RECORDS TO BE TRANSMITTED ELECTRONICALLY AND ABSOLVE NEUROLOGICAL SURGEONS OF DALLAS, P.A. OF ANY AND ALL LIABILITY IF THEY ARE RECEIVED BY ANOTHER PARTY IN ERROR.

SIGNATURE OF PATIENT OR PARENT IF MINOR DATE

INITIAL AND DATE_______________________________