Patient Information Form

Workers Comp ❑
Auto Accident ❑
Other ❑

(Please Print)

Date ____________________ Referred by ____________________

Patient's Name ____________________ Phone # ____________________
Address ____________________ Cell Phone # ____________________
City ____________________ State ________ Zip ____________________
Age ________ Birthdate ____________________ Sex ________ Social Security # ____________________
E-mail Address ____________________

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Alternate Contact ____________________ Phone # ____________________

Patient/Parent/Guardian Employer ____________________ Phone # ____________________
Address of Employer ____________________ Type of work ____________________

Spouse's Name ____________________ Employer ____________________ Phone # ____________________
Spouse's Employer's address ____________________ Type of Work ____________________

FIRST INSURANCE ____________________ Policyholder ____________________
Address ____________________
Phone # ____________________ Policy # ____________________ Group # ____________________
Policyholder's Social Security # ____________________ Policyholder's Birthdate ____________________

SECOND INSURANCE ____________________ Policyholder ____________________
Address ____________________
Phone # ____________________ Policy # ____________________ Group # ____________________
Policyholder's Social Security # ____________________ Policyholder's Birthdate ____________________

Nearest Relative not living with you/Relationship ____________________ Phone # ____________________
Address ____________________
If you have retained an attorney, please give: Name ____________________
Address ____________________ Phone # ____________________

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Baptist Neurology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize Baptist Neurology and its employees and agents, to release all information, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals and doctors.

Signed (Insured Person) ____________________ Date ____________________

Responsible Person if Patient is a Minor ____________________