WELCOME TO METROLINA NEUROLOGICAL ASSOCIATES, PA

NEW PATIENT INFORMATION

Title: Last Name: First Name: MI

Street Address: Apt:

Zip Code: City: State:

Home Phone: Cell Phone: Work Phone:

Email Address:

Social Security Number:

Birthday: Sex: Race: Primary Care Doctor:

Marital Status: Employment: FT___PT____Unemployed____Retired____Student____

Emergency Contact Name:

Address and Phone Number:

INSURANCE INFORMATION/WORKERS COMPENSATION

Primary Insurance Company Name:
Address:
Policy Holder Name: Insured DOB:
Telephone Number:

Policy Number: Group Number: Effective Date:
Secondary Insurance Company Name:
Address:
Policy Holder Name: Insured DOB:
Telephone Number:
Policy Number: Group Number: Effective Date:

Workers Compensation: Date of Injury_____
Name of Carrier and Address:
Contact Person Name and Telephone Number:
Name of Employer:
Employers Address and Telephone Number:

I authorize the release of any medical information necessary to process insurance claims. I request payment of benefits either to myself or the party who accepts assignment. I understand that I am financially responsible for payment or charges not covered by this authorization. I voluntarily consent to treatment at this facility from physicians and staff. No guarantees have been made to me about the results or treatments or examination by staff at this practice. I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations. I have read this form and have had the opportunity to ask questions.

_____Patient or Guardian _____Date