*Welcome to our office*

Date: _____

# ATLANTA NEUROLOGY, P.C.

Account #: _____

## PATIENT INFORMATION

Title
Name First M.I. Last

Address City State Zip

Home Phone ( ) Cell or Alternate # ( ) S.S. #

Birthdate Age Sex: (Circle) M F Marital Status ☐M ☐S ☐D ☐W

Race: ☐White ☐African American ☐Asian
☐American Indian or Alaskan Indian
☐Native Hawaiian / Other Pacific Islander
☐Other Race_____ ☐Unknown

Ethnicity: ☐Decline ☐Hispanic or Latino
☐Not Hispanic or Latino
Preferred Method of Contact: ☐Home ☐Cell ☐Work
☐Email _____

**Spouse**

Spouse's Name **DOB:** Cell # ( )

Work
Patient's Employer Phone ( )

Address City State Zip

Local Relative or Friend Phone ( )

Pharmacy Name: Phone ( )

## INSURANCE INFORMATION

Primary Insurance Company Phone ( )

Insured's Name I.D. # Group #

Secondary Insurance Company Phone ( )

Insured's Name I.D. # Group #

**REFERRING PHYSICIAN:**

## IS POLICYHOLDER OTHER THAN SELF? IF SO PLEASE COMPLETE BELOW:

☐ Primary Insurance ☐ Secondary Insurance

Policyholders
Name First M.I. Last Relationship: (Circle One)
Spouse, Parent, Other

SS#: DOB: Employer:

Home Phone ( ) Work Phone ( )

*I authorize payment of health insurance benefits directly to Atlanta Neurology for services rendered, and I authorize the use of this signature for all insurance claims. Regulation pertaining to medical assignment of benefits apply. I authorize the release of any medical information necessary to secure payment of benefits. I further authorize the release of medical information to other physicians and hospitals involved in my treatment. I permit a copy of this authorization to be used in place of the original.*

*I agree that I am responsible for understanding my health insurance policy and its requirements for coverage, and for complying with any regulations my insurance may have regarding referrals and pre-authorizations. Co-pays, deductible and/or co-insurance payments are due at the time services are provided. I agree to make immediate payment in full of any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further agree to pay all reasonable costs of collection and attorney's fees, if any.*

**Signature** _____ Date _____