

NEW PATIENT INFORMATION SHEET

(Please print, fill out, and bring on your first visit.)



Patient's Name (Last) _____ (First) _____ (Middle Initial) _____

Address _____ Apt.# _____

City _____ State _____ Zip _____

Home Phone # _____ Business # _____ Cell Phone # _____

Date of Birth _____ SS# _____

Age _____ Sex _____ Marital Status _____

Occupation _____ Employer _____

Employer's Address and Phone _____

Name of Referring Physician _____ Tel. # _____

Address _____ City _____ State _____ Zip _____

Person to contact in case of an emergency _____

Phone# _____ Relationship _____

Primary Insurance Plan Name _____

Secondary Insurance Plan Name _____

Signature and Release: I, the undersigned, certify that the above information is correct and assign all payments made on my behalf by my insurance carrier (s) directly to Neurology Consultants of New York. I hereby authorize the release of any and all information necessary to obtain payment of benefits for services provided to me. I understand that I am responsible for any and all charges not covered by my insurance carrier due to the lack of such benefits within my plan or due to my lack of coverage for any reason. I understand that I am also responsible for any co-insurance, deductibles, and co-payments.

Patient Signature

Relationship to patient, if not patient

Date