# CONNECTICUT NEUROLOGICAL SPECIALIST, LLC PATIENT INFORMATION SHEET

**DATE _____**

**PATIENT NAME** _____ **HOME PHONE (  ) _____**
LAST FIRST MIDDLE

**WORK PHONE (  ) _____ CELL PHONE (  ) _____ CIRCLE SINGLE _ MARRIED __ DIVORCED__WIDOW__**

**HOME ADDRESS:**_____
STREET TOWN/CITY STATE ZIP CODE

**SOCIAL SECURITY#** _____ **DATE OF BIRTH** _____/_____/_____ **SEX M / F**
Month Date Year

**EMERGENCY CONTACT**_____**PHONE (  ) _____**

**PRIMARY CARE PHYSICIAN (PCP)** _____ **PHONE (  ) _____**
LAST FIRST CITY STATE

**REFERRING PHYSICIAN** _____ **PHONE (  )_____**
LAST FIRST CITY STATE
(IF DIFFERENT)

**GUARANTOR - COMPLETE IF DIFFERENT FROM PATIENT** **DATE OF BIRTH FOR GUARANTOR** _____/_____/_____

**PATIENT RELATION TO GUARANTOR:** **1) ☐ SELF** **2) ☐ SPOUSE** **3) ☐ DEP CHILD** **4) ☐ OTHER** _____

**NAME** _____ **SS#** _____

**ADDRESS** _____**PHONE (  ) _____**
STREET CITYSTATE ZIP CODE

**EMPLOYER NAME** _____**EMPLOYER PHONE (  ) _____**

**IS THIS WORK-RELATED? ☐ YES ☐ NO** **IS THIS A RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO**

**EMPLOYER CONTACT** _____ **DATE OF INJURY** _____/_____/_____

## PRIMARY INSURANCE INFORMATION

**INSURANCE NAME** _____

**ADDRESS** _____

**INSURANCE PHONE (  )** _____

**SUBSCRIBER NAME** _____

**SUBSCRIBER DOB** _____/____/_____ **SUBSCRIBER SEX---> M ☐ F ☐**

**SUBSCRIBER ADDRESS** _____

**PATIENT RELATION TO SUBSCRIBER:**
**☐ SELF ☐ SPOUSE ☐ DEP CHILD ☐ OTHER** _____

**SUBSCRIBER ID#** _____

**GROUP NAME/#** _____

**CONTRACT TYPE** _____ **EFFECTIVE DATE** ____/____/___

**SUBSCRIBER SS#** _____

**IF INSURANCE OFFERED BY AN EMPLOYER, PLEASE INDICATE EMPLOYER**

**NAME:** _____

## SECONDARY INSURANCE INFORMATION

**INSURANCE NAME** _____

**ADDRESS** _____

**INSURANCE PHONE (  )** _____

**SUBSCRIBER NAME** _____

**SUBSCRIBER DOB** _____/____/_____ **SUBSCRIBER SEX---> M ☐ F ☐**

**SUBSCRIBER ADDRESS** _____

**PATIENT RELATION TO SUBSCRIBER:**
**☐ SELF ☐ SPOUSE ☐ DEP CHILD ☐ OTHER** _____

**SUBSCRIBER ID#** _____

**GROUP NAME/#** _____

**CONTRACT TYPE** _____ **EFFECTIVE DATE** ____/____/___

**SUBSCRIBER SS#** _____

**IF INSURANCE OFFERED BY AN EMPLOYER, PLEASE INDICATE EMPLOYER**

**NAME:** _____

## INSURANCE AUTHORIZATION AND ASSIGNMENT

**I hereby assign payment of the medical and/or major medical benefits, if any, otherwise payable to me for this service, directly to the designated physician and/or Connecticut Neurological Specialist. This authorization is valid for any and all insurance claims filed for me by Connecticut Neurological Specialist to the insurance companies listed above. This authorization is valid from this date until written notice of cancellation is received in the offices of Connecticut Neurological Specialist. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO CONNECTICUT NEUROLOGICAL SPECIALIST AND/OR DESIGNATED PHYSICIAN FOR CHARGES NOT COVERED OR PAID BY THIS ASSIGNMENT.**

**I hereby authorize the designated physician to release any information acquired in the course of my examination and treatment to the insurance company(ies) listed above, and any other physician or health care facility where Connecticut Neurological Specialist may refer me for further care.**

_____ _____

**Signature of Insurance Holder** **Date Signed** **Signature of Responsible Individual** **Date Signed**