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NEW Patient Information Sheet

Name (first)_____ MI____ Last_____
Date of birth_____Gender ___ Marital status_____
Address (street) _____
(City, state, zip)_____e-mail _____
Phone #_____ cell #_____Driver lic. Or ID#_____
Employer name and address _____
Work phone #_____If student, school name_____
Referring physician / _____

RESPONSIBLE PARTY, SIGNIFICANT "OTHER" OR SPOUSE INFORMATION

Name_____Relationship to patient_____
Address (street)_____
(City, state & zip)_____
Phone #_____Driver Lic./ID#_____
Work #_____Employer name/address_____
Friend or relative not living with you _____Phone#_____

INSURANCE INFORMATION

Medicare #_____ Insurance Company: _____
Insured's Name_____ Relationship to patient _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Address:_____
Phone#:_____

I hereby assign, transfer and set over to Neuron Medical Corp. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.
A $100.00 cancellation fee will be charged to any and all patients who do not cancel their appointment within 24 hours prior to their scheduled appointments.

Patient's signature_____Date_____