Liliana Cohen, M.D
Kristin Stiles Green, N.M.D
Paul Dudley, M.D.
Vijay Kumar, M.D.
227 W. Janss Rd. #135 Thousand Oaks, CA 91360 Tel (805) 373-2890 Fax (805) 364-5464
Neuronoffice@gmail.com

NEW Patient Information Sheet
NATUROPATHIC MEDICINE
Dr. Green

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 Agree to Terms *:

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____________________________