NEW PATIENT INFORMATION FORM

Neuron Medical Corp.
2220 Lynn Rd , #204
Thousand Oaks, CA 91360
Tel (805) 373-2890
NeuronOffice@gmail.com

Name (first)_____MI____ Last_____

Date of birth_____ Gender _____ Marital status_____

Address (street, city, state, zip code) _____

Email Address _____

Phone numbers: cell, home, work _____

Employer name and address_____

Work phone #_____ If student, school name: _____

Referring physician/healthcare providers _____

RESPONSIBLE PARTY

Name_____ Relationship to patient_____

Address (street, city, state, zip code) _____

Phone # _____Work #_____

Employer name/address if working _____

EMERGENCY CONTACT NAME & RELATIONSHIP _____

Phone #s _____

PHARMACY INFORMATION

Preferred Pharmacy: _____Address: _____

Phone#: _____

I hereby assign, transfer and set over to Neuron Medical Corp., all 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 they are covered by insurance or not.
A $100 cancellation fee will be charged to all patients who do not cancel their appointment within 24 hours prior to their scheduled appointment.
The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Patient's signature_____ Date _____