

# Overlake Neurology, Inc., P.S.

## New Patient Information Form

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Patient Complaint or Diagnosis: \_\_\_\_\_

## Patient Information

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Sex:  Male  Female Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Mailing Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_  
(Name) (Address)

Responsible Party:  Self or \_\_\_\_\_  
(Relationship)

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

### For Emergency Contact Nearest Relative or Friend:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State/Zip)

Health Care Proxy:  Yes  No

## Health Insurance Information

### Primary Health Insurance:

Insurance Company Name: \_\_\_\_\_

Employer Sponsor: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
(Mailing) (City) (State/Zip)

Subscriber relationship to patient:  Self  Spouse  Parent  Other

Subscriber Name: \_\_\_\_\_

Certification ID #: \_\_\_\_\_ Policy Group or Plan #: \_\_\_\_\_

### Secondary Health Insurance:

Insurance Company Name: \_\_\_\_\_

Employer Sponsor: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
(Mailing) (City) (State/Zip)

Subscriber Relationship to Patient:  Self  Spouse  Parent  Other

Subscriber Name: \_\_\_\_\_

Certification ID #: \_\_\_\_\_ Policy Group or Plan #: \_\_\_\_\_

## Release of Information/ Payment Authorization

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date