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### NEW PATIENT INFORMATION SHEET

Name (first) \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital status \_\_\_\_\_ Social security # \_\_\_\_\_  
Address (street) \_\_\_\_\_  
(City, state, zip) \_\_\_\_\_ e-mail \_\_\_\_\_  
Phone # \_\_\_\_\_ cell # \_\_\_\_\_ Driver lic. Or ID# \_\_\_\_\_  
Employer name and address \_\_\_\_\_  
Work phone # \_\_\_\_\_ If student, school name \_\_\_\_\_  
If student, part time or full time \_\_\_\_\_ Referring physician \_\_\_\_\_

### RESPONSIBLE PARTY, SIGNIFICANT "OTHER" OR SPOUSE INFORMATION

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address (street) \_\_\_\_\_  
(City, state & zip) \_\_\_\_\_  
Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver Lic./ ID# \_\_\_\_\_  
Work # \_\_\_\_\_ Employer name/address \_\_\_\_\_  
Friend or relative not living with you \_\_\_\_\_ Phone# \_\_\_\_\_

### INSURANCE INFORMATION

Medicare # \_\_\_\_\_ Medical/aid # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_  
Insurance address \_\_\_\_\_  
Group # \_\_\_\_\_ Certificate or ID # \_\_\_\_\_  
Insured's name \_\_\_\_\_ Relationship to patient (if not 'self') \_\_\_\_\_  
Insured's employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Insured employer's address \_\_\_\_\_  
Insured's Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

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. **\$50.00 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 \_\_\_\_\_