Patient NEW Information Form

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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 #_____Insurance Co: _____
Insured's Name_____Relationship to patient (if not "self")_____

Pharmacy Information

Preferred Pharmacy Name: _____
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 $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_____