Collier Neurologic Specialist Patient Information Form

Doctor: *Baker Colon Cox Justiz Krueger Mercer Nunez Santiago Smith*
(Please circle)

Referring Physician:_____ Primary Physician:_____ New Pt ☐ Est Pt ☐

Last Name_____First Name_____SS#_ _ _ -_ _ -_ _ _

Date of birth _____ Gender (circle) **M F Other Declined**

Local Address_____

City_____State_____Zip_____ Marital Status: S M D W

Phone ( )_____ Cell Phone ( )_____

Employer_____ Phone ( )_____Ext_____

Northern Address_____

City_____State___ Zip_____ Phone ( )_____

In case of an emergency, who should we contact?

Name_____Relationship_____

Phone_____

NEW

******IF YOU WOULD LIKE TO COMMUNICATE WITH YOUR PROVIDER, REVIEW YOUR**** MEDICAL RECORDS, REQUEST RX REFILLS, APPOINTMENTS, OR VIEW YOUR ACCOUNT ELECTRONICALLY VIA OUR SECURE WEBSITE**
PLEASE ENTER YOUR EMAIL ADDRESS BELOW AND WE'LL SEND YOU AN INVITATION

Email:_____

LANGUAGE: English ☐ Spanish ☐ Other ☐ Refused ☐

ETHNICITY: Latino/Hispanic ☐ Other ☐ Refused ☐

RACE: Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other ☐ Refused ☐

Payment Method: Medicare ☐ Commercial Ins. ☐ Self Pay ☐ Cash ☐ Credit/Debit ☐ Check ☐

If you are <u>not</u> the Policy Holder on your insurance, please complete below.

Policy holder's name_____DOB_____SS#_____