G. GARY LIAN, M.D., Ph.D., Shoreline Neurology, LLC
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Office Use ONLY:

PATIENT INFORMATION

LAST NAME	FIRST NAME	M. INITIAL	REASON FOR REFERRAL/VISIT

MAILING ADDRESS (Include physical address if PO Box)	CITY	STATE	ZIP CODE

BIRTHDATE	MARITAL STATUS	SOCIAL SECURITY NO. ***(Required by Insurance)***	TELEPHONE NO./EMAIL
_____/_____/_____ m d y AGE _____ GENDER _____	☐ S ☐ M ☐ W ☐ D ☐ Separated ☐ Other	_____-_____-_____	Home _____ Cell _____ Work _____ Email _____

OCCUPATION (if student, name of school)	EMPLOYER	WORK ADDRESS

EMERGENCY CONTACT	PHONE	RELATIONSHIP

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	

PHARMACY INFORMATION

NAME OF PHARMACY	PHARMACY ADDRESS (Town, State)	PHARMACY PHONE	PHARMACY FAX

ACCIDENT INFORMATION (If applicable)

TYPE OF INJURY	DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY:
☐ AUTO ☐ OCCUPATIONAL ☐ OTHER			INSURANCE CONTACT:

INSURANCE COVERAGE

NAME OF **PRIMARY** INSURANCE			BILLING ADDRESS		
NAME OF INSURED	BIRTHDATE OF INSURED _____/_____/_____ m d y	SUBSCRIBER NO. _____ GROUP NO. _____	SOCIAL SECURITY NO. ***(Insurance needs for verification purposes)*** _____-_____-_____	GROUP INS. W/EMPLOYER? ☐ YES ☐ NO	NAME OF EMPLOYER
NAME OF **SECONDARY** INSURANCE, IF ANY			BILLING ADDRESS		
NAME OF INSURED	BIRTHDATE OF INSURED _____/_____/_____ m d y	SUBSCRIBER NO. _____ GROUP NO. _____	SOCIAL SECURITY NO. ***(Insurance needs for verification purposes)*** _____-_____-_____	GROUP INS. W/EMPLOYER? ☐ YES ☐ NO	NAME OF EMPLOYER

FINANCIAL RESPONSIBILITY (Please complete if not the patient)

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NO.
			_____-_____-_____

RELATIONSHIP TO PATIENT	TELEPHONE NO. Home _____ Other _____	ADDRESS	
PLACE OF EMPLOYMENT	WORK ADDRESS	OCCUPATION	HOW LONG?

AUTHORIZATION

- I understand that I am financially responsible to G. Gary Lian, M.D. for any charges incurred by the above-named patient, and promise to pay to G. Gary Lian, M.D. the amount of such charges which are not paid by any insurance carrier for any reason.
- I authorize the release of any medical or financial information to the above-named insurance company necessary to process claims and the release of payment of medical benefits for any services performed by G. Gary Lian, M.D. directly to G. Gary Lian, M.D.
- I authorize G. Gary Lian, M.D. or his representative to speak to _____ or leave information on my voicemail regarding appointments and other personal information related to my medical care.

_____ _____

Signature of Patient or Responsible Party Date