ROCKY MOUNTAIN NEUROLOGICAL ASSOCIATES

PATIENT DEMOGRAPHICS - PLEASE COMPLETE ALL INFORMATION

Name: Last ______________________ First ______________________ Initial
Address ______________________
City, State, Zip Code ______________________
Phone Numbers: Home ( )____ - ______ Work ( ) ____ - ______ Cell ( ) ____-______
Preferred Method of Communication: Home ☐ Work ☐ Cell ☐
Employer Name ______________________
Sex: Female Male Marital Status: Single Married Widowed Divorced
Birth date (mm/dd/yy) ____ / ____/ ______________ Soc Sec #_______-______ -__________
Ethnicity: Decline to Specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐
Race: Decline to Specify ☐ American Indian or Alaskan Native ☐ Asian ☐
Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐
Preferred Language ______________
Nearest relative not living with you ______________________
Relationship ______________________ Phone Number ( ) ____-______
Referring Physician ______________________ Physician's Phone ( ) ____-______
Ref. Physician's Address ______________________

RESPONSIBLE PARTY INFORMATION

Name: Last ______________________ First ______________________ Initial
Address ______________________
City, State, Zip Code ______________________
Phone Numbers: Home ( )____ - ______ Work ( )____ -_______ Cell ( )____ - ______
Birth date (mm/dd/yy) ____ /________ Soc Sec #_______-______-________
Employer Name ______________________
Employer Address ______________________

INSURANCE INFORMATION

Primary Insurance ______________________ Phone ( ) ____-______
Insured's Name ______________________ Relationship ______________________
Insurance Address ______________________
City, State, Zip Code ______________________
ID/Subscriber# ______________________ Group# ______________________
Employer Name ______________________ Phone ( ) ____-______
Contact Person ______________________ Pre-Auth Needed ? ______________

Secondary Insurance ______________________ Phone ( )____ - __________
Insured's Name ______________________ Relationship
Insurance Address ______________________
City, State, Zip Code ______________________
ID/Subscriber# ______________________ Group# ______________________
Employer Name ______________________ Phone ( ) ____-______

PLEASE COMPLETE **THE OTHER** SIDE

PAYMENT EXPECTED AT TIME OF SERVICE

I, the undersigned, give permission to release information to 3'd party carriers and do assign all insurance benefits for treatment to be paid directly to the above named provider, and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be valid as the original.

I, the undersigned, recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

AUTHORIZATION TO RELEASE INFORMATION

I/we hereby authorize the doctor, named above, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

______________________________ ________________________

Signature of Responsible Party Date

Change of Address

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PLEASE COMPLETE **THE OTHER** SIDE