CAREFREE NEUROLOGY CLINIC

Today's Date: [Date]			PCP: [PCP]		
PATIENT INFORMATION					
Patient's last name: First:		Middle: [Choose an item]	Marital status: [Choose an item]		
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date: [Birthday]	Age: [Age]	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security no.:	Home phone no.: [Phone]		Cell phone no.: [Phone]		
Occupation:	Employer:		Employer phone no.: [Phone]		
Chose clinic because/referred to clinic by (Please choose one option):	○ [Doctor's name] ○ [Choose an item]				
Other family members seen here: [Other patients]					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: [Birthday]	Address (if different):	Home phone no.:		
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance:		Other: [Other insurance]			
Subscriber's name:	Subscriber's S.S. no.: [SS#]	Birth date: [Birthday]	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					
Name of secondary insurance (if applicable): [Secondary Insurance]		Subscriber's name: [Name]	Group no.: [Group #]	Policy no.: [Policy #]	
Patient's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]					

34406 N.27th drive, bldg1, suite 102, Phoenix, AZ 85085 | Phone: 602-344-9567 | FAX: 602-344-9562

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IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CAREFREE NEUROLOGY CLINIC or insurance company to release any information required to process my claims. Patient/Guardian signature		Date	