

MIDWEST NEUROSCIENCE, P.C.

Welcome to our office. In order to serve you properly, we need the following information.  
PLEASE PRINT. All information will be strictly confidential.

Patient name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Phone \_\_\_\_\_ Marital status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell phone \_\_\_\_\_ Pager \_\_\_\_\_

Patient or minor employer \_\_\_\_\_ Work phone \_\_\_\_\_

Spouse employer \_\_\_\_\_ Work phone \_\_\_\_\_

Person to contact in case of emergency:

Name \_\_\_\_\_ relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

Name \_\_\_\_\_ relationship to patient \_\_\_\_\_

Address (if different than patient) \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

INSURANCE INFORMATION - WE MUST HAVE A COPY OF INSURANCE CARDS

Primary Insurance \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Insured name \_\_\_\_\_ relationship to patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Insured name \_\_\_\_\_ relationship to patient \_\_\_\_\_

IS THIS WORK COMP OR MOTOR VEHICLE ACCIDENT? If yes, we must have all info needed to file work comp including authorization or patient will not be seen. WE DO NOT FILE MOTOR VEHICLE, THIS IS DUE BY PATIENT.

Work comp carrier \_\_\_\_\_ Claim# \_\_\_\_\_

Treatment authorized by \_\_\_\_\_ Phone \_\_\_\_\_

REFERRING PHYSICIAN

Name \_\_\_\_\_ Phone \_\_\_\_\_

List any other physicians to release records to \_\_\_\_\_

Sign for permission to release records to above: \_\_\_\_\_

ASSIGNMENT OF MEDICARE AND INSURANCE BENEFITS, RELEASE OF INFORMATION:

I authorize payment of Medicare or private insurance benefits to Midwest Neuroscience, P.C. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to Medicare and my insurance company information concerning health care, advice or treatment provided to me.

\_\_\_\_\_  
Patient or parent if patient is a minor

\_\_\_\_\_  
Date