

NEUROLOGY SPECIALISTS OF NORTHERN ILLINOIS

WELCOME!

Thank you for selecting our healthcare team. We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions, or need assistance, please ask us – we will be happy to help.

TODAY'S DATE: _____

SECTION 1 PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Social Security # : _____ Birth date: _____ Male Female

Marital Status: Married Single Widowed Divorced

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Referring Physician: _____ Phone number: _____

SECTION 2 PREFERENCES

I wish to be addressed as (called): _____

Where do you prefer to receive calls? Home Work Cell

When is the best time to reach you? Time: _____ Days: _____

SECTION 3 EMERGENCY CONTACT

Please list someone who does NOT live with you as well as spousal information (if applicable):

Name: _____ Relationship: _____

Work Phone: _____ Home Phone: _____

Cell Phone: _____

Spouse's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

**SECTION 4
INSURANCE INFORMATION**

Primary Insurance

Name of Insured: _____

Insured's Birthdate: _____

SS#/SIN: _____

Employer: _____

Date Employed: _____

Occupation: _____

Insurance Co.: _____

Group # : _____

Cert/ID # : _____

Plan # : _____

Ins. Co. Address: _____

Secondary Insurance

Name of Insured: _____

Insured's Birthdate: _____

SS#/SIN: _____

Employer: _____

Date Employed: _____

Occupation: _____

Insurance Co.: _____

Group # : _____

Cert/ID # : _____

Plan # : _____

Ins. Co. Address: _____

Section 5

WORKER'S COMPENSATION OR MOTOR VEHICLE ACCIDENT

If this is a worker's compensation case or motor vehicle accident, the following information is required. If information is not furnished, you will be billed for services directly.

Employer: _____ Contact person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Case Number: _____

WC or Auto Ins. Co.: _____ Contact person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Section 6

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor

Date