

Date: _____

ATLANTA NEUROLOGICAL ASSOCIATES, P.C.

**Patient's Full LEGAL Name: _____

LAST FIRST MIDDLE MAIDEN

Sex: Male or Female Birthdate: Month - _____ Day - _____ Year - _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work#: _____ Cell #: _____

Patient's Social Security Number: _____ Occupation: _____

Patient's Employer: _____

Marital Status: _____ Spouse's or Guardian's Name: _____

Spouse or Guardian's Employer: _____ Phone #: _____

**In Case of Emergency, Please List Contact Person Other Than Above: _____

Name: _____ Relation: _____ Phone: _____

**Who Is Your Referring Physician?: _____ Phone #: _____

Address: _____ Reason for this visit? _____

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INSURANCE INFORMATION  
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PRIMARY POLICY #1 SECONDARY POLICY #2

Insurance Co Name: _____ Insurance Co Name: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

*Name of insured? _____ Name of insured? _____

*Insured's Date of Birth: _____ Insured's Date of Birth: _____

Place Copy of Ins Card(s) Here

WORKER'S COMPENSATION

Please Check in with Receptionist Prior to Visit to Verify Benefits and Obtain Authorization!!

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PATIENT / GUARANTOR STATEMENT  
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I consent to the release of information about me to my insurance company, any governmental payor, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I consent to the use/release of medical information about me for purposes of health care operations, for example, quality assurance activities. This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has taken action in reliance upon my consent. I also understand that I am responsible for PAYMENT IN FULL for services rendered.

I have read and I understand this document.

SIGNATURE: _____ DATE: _____

Patient / Guarantor