

# WESTERN NEUROLOGICAL ASSOCIATES, P.C.

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 EEG

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Date: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Initial: \_\_\_\_\_

PATIENT INFORMATION				HEALTH INSURANCE			
Patient's Name- Last		First		Middle		Primary Insurance	
Sex	Date of Birth		Age	Marital Status		Group Number	Policy Number
Social Security Number		Best Day Phone		Name of Policy Holder		Insured Date of Birth	
Street Address			Apt #	Insurance Company Address , Street, City, State, Zip			
P.O. Box				Secondary Insurance			
City, State,		Zip		Group Number		Policy Number	
Home Phone		Cell Phone		Name of Policy Holder		Insured Date of Birth	
Employer/Retired			Work Phone	Insurance Company Address , Street, City, State, Zip			
Employers Address, Street, City, State, Zip				MANDATORY INFORMATION FOR INSURANCE			
Spouse's Name				Briefly Describe your symptoms			
Spouse's Employer			Spouse's Work Phone	<b>WHEN DID THEY BEGIN?</b>			
Month:		Day:		Year:			
CONTACT INFORMATION				ACCIDENT/ INJURY INFORMATION			
Relative /Friend (Not at your address)				Type of Injury or Accident?	Auto	Industrial	Other
Address, Street, City, State, Zip				Date of Injury/Accident:		State where Occurred:	
Phone		Relationship		If Industrial or Other How Accident Happened:			
REFERRING PHYSICIAN				Insurance Company Name		Claim Number	
Doctor who Referred You (First and Last Name Please)				Address: Street, City, State, Zip			
Address: Street, City, State, Zip				Adjusters Name		Phone Number	
Phone Number:				Employer at time of Accident if Industrial			
IF PATIENT IS A MINOR, FILL IN BACK PAGE				Employer Address: Street, City, State, Zip			

I hereby authorize the above checked physician to furnish my designated insurance carrier(s) all information concerning my present illness or injury. I also authorize benefits under this claim to be made payable directly to the physician. Should any balance remain after 90 days, I will pay interest at the annual rate of 12% (1% per month) starting from the date the charges were made. I understand that delinquent accounts are turned over to a collection agency. If the account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection agency fee of 25%, which will be added to the outstanding balance of my account with or without suit.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_