

# WESTERN NEUROLOGICAL ASSOCIATES, P.C.

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EEG

Brian R. Mumford, M.D.

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

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

Initials: \_\_\_\_\_

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 (9 Digit)		
P.O. Box				Secondary Insurance		
City, State		Zip Code- <u>9 DIGIT PLEASE</u>		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 (9 Digit)		
Employer's Address: Street, City, State, Zip (9 Digit)				<b>MANDATORY INFORMATION FOR INSURANCE</b>		
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				ADDITIONAL INFORMATION NEEDED		
Relative / Friend (Not at your address)				Please circle appropriate response in each column		
Address: Street, City, State, Zip				<b>LANGUAGE</b>	<b>ETHNICITY</b>	<b>RACE</b>
Phone		Relationship		Arabic	Hispanic or Latino	American Indian or Alaska Native
				English		
<b>REFERRING PHYSICIAN</b>				French	Not Hispanic or Latino	Asian
				Doctor who Referred You (First and Last Name Please)		
Address: Street, City, State, Zip (9 Digit)				Japanese	Declined	Black or African American
				Phone Number:		
<b>IF PATIENT IS A MINOR, FILL IN BACK PAGE ACCIDENT OR INJURY PLEASE FILL IN BACK PAGE</b>				Mandarin Chinese		Native Hawaiian or Other Pacific Islander
				Russian		White
				Other		Declined

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 up to 40%, which will be added to the outstanding balance of my account with or without suit.

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

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

ACCIDENT / INJURY INFORMATION			
Type of Injury or Accident?	Auto	Industrial	Other
Date of Injury/Accident:		State where Occurred:	
If Industrial or Other How Accident Happened:			
Insurance Company Name		Claim Number	
Address: Street, City, State, Zip (9 Digit)			
Adjusters Name		Phone Number	
Employer at time of Accident if Industrial			
Employer Address: Street, City, State, Zip (9 Digit)			

FILL IN IF PATIENT IS A MINOR	
Mother's Name (First, Middle, Last)	SS#
Employer	Employer Phone
Employer's Address (City, State)	Zip (9 Digit)
Father's Name (First, Middle, Last)	SS#
Employer	Employer Phone
Employer's Address (City, State)	Zip (9 Digit)
Bill To/Responsible Party Name (First, Middle, Last)	
Address	
City, State, Zip (9 Digit)	Phone Number