ROCKY MOUNTAIN NEUROLOGICAL ASSOCIATES

DIANA D. BANKS, M.D. EVAN G. BLACK, M.D.

PATIENT DEMOGRAPHICS – PLEASE COMPLETE ALL INFORMATION

Name: Last_____ First _____ Initial____

Address_____

City, State, Zip Code_____

Please circle the phone number you are most likely to be reached

Phone Numbers: Home ( ) _____-_____ Work ( ) _____-_____ Cell ( ) _____-_____

Sex F M Marital Status S M W D

Birth date (mm/dd/yyyy)_____/_____/_____ Soc Sec #_____-_____-_____

Employer Name_____

Referring Physician_____ Phone ( ) _____-_____

Ref Physician's Fax ( ) _____-_____ Address_____

Primary Care Physician_____ Phone ( ) _____-__

Primary Care Physician's Fax ( ) _____-_____ Address_____

RESPONSIBLE PARTY INFORMATION

Name: Last_____ First _____ Initial____

Address_____

City, State, Zip Code_____

Phone Numbers: Home ( )_____-_____ Work ( )_____-_____ Cell ( )_____-_____

Birth date (mm/dd/yyyy)_____/_____/_____ Soc Sec #_____-_____-_____

Employer Name_____

EMERGENCY CONTACT INFORMATION

Name: Last_____ First _____ Initial____

Address_____

City, State, Zip Code_____

Phone Numbers: Home ( )_____-_____ Work ( )_____-_____ Cell ( )_____-_____

INSURANCE INFORMATION

Primary Insurance_____ Phone ( )_____-_____

Insured's Name_____ Relationship_____

Insurance Address_____

City, State, Zip Code_____

ID/Subscriber#_____ Group#_____

Secondary Insurance_____ Phone ( )_____-_____

Insured's Name_____ Relationship_____

Insurance Address_____

City, State, Zip Code_____

ID/Subscriber#_____ Group#_____

PLEASE COMPLETE THE OTHER SIDE

COPY ALL INSURANCE CARDS AND PICTURE ID BELOW

PAYMENT EXPECTED AT TIME OF SERVICE

I, the undersigned, give permission to release information to 3rd party carriers and do assign all insurance benefits for treatment to be paid directly to the above named provider, and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be valid as the original.

I, the undersigned, recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

AUTHORIZATION TO RELEASE INFORMATION

I/we hereby authorize the doctor, named above, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

_____ _____

Signature of Responsible Party Date