TEXAS NEUROLOGY

Patient Information

Name: _____ Date of birth: _____
First MI Last

Address: _____

City: _____ State: _____ Zip: _____

Residence Type: ❑ Private Residence ❑ Skilled Nursing Facility or Hospice ❑ Nursing Home

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Partnered ❑ Widowed ❑ Legally Separated ❑ Other

Employer: _____ Occupation: _____

Home Phone	**Cell Phone**	**Work Phone**
(_____) _____ - _____	(_____) _____ - _____	(_____) _____ - _____
❑ This is my preferred number	❑ This is my preferred number	❑ This is my preferred number
May we leave personal/medical information on your voicemail? ❑ Yes ❑ No	May we leave personal/medical information on your voicemail? ❑ Yes ❑ No *I understand that a cellular phone is not a secure and private line.	

Email: | | | | | | | | | | | | | | | | | | | | | | | | |

How Did You Hear About Us?

❑ Physician/Provider Referral ❑ Family or Friend ❑ Website or Search Engine ❑ Other

Insurance Coverage

Primary Insurance	**Secondary Insurance**
	❑ I do not have a secondary insurance
Carrier: _____	Carrier: _____
ID#: _____	ID#: _____
Group#: _____	Group#: _____
Name of insured: _____	Name of insured: _____
Insured's date of birth: _____	Insured's date of birth: _____
Relationship to insured: ❑ Self ❑ Spouse ❑ Other: _____	Relationship to insured: ❑ Self ❑ Spouse ❑ Other: _____

By signing this form I authorize:

1. The release of any medical and/or other information necessary to process my claims.
2. Payment of medical benefits to my treating physician or supplier for services rendered by Texas Neurology.

x _____ x _____
Patient/Guardian Signature *Date*

6301 Gaston Avenue, Suite 100, West Tower, Dallas, Texas 75214
(214) 827-3610 (Telephone) / (214) 821-4017 (HIPAA Fax)
http://www.texasneurology.com

TEXAS NEUROLOGY

Name: _____ Date of birth: _____
First MI Last

Primary Emergency Contact

Please check a box below indicating whether or not you would like to have this Primary Emergency Contact added as an authorized HIPAA contact.

- ❑ I authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact
- ❑ I do **NOT** authorize the disclosure of my protected health information to the person listed as my Primary Emergency Contact

Name: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Relationship: ❑ Spouse ❑ Partner ❑ Sibling ❑ Parent ❑ Child ❑ Friend ❑ Other: _____

Secondary Emergency Contact

Please check a box below indicating whether or not you would like to have this Secondary Emergency Contact added as an authorized HIPAA contact.

- ❑ I authorize the disclosure of my protected health information to the person listed as my Secondary Emergency Contact
- ❑ I do **NOT** authorize the disclosure of my protected health information to the person listed as my Secondary Emergency Contact

Name: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Relationship: ❑ Spouse ❑ Partner ❑ Sibling ❑ Parent ❑ Child ❑ Friend ❑ Other: _____

Primary Care Provider

Name: _____ Phone: (_____) _____ - _____

Primary Pharmacy

Type: ❑ Local Pharmacy ❑ Mail-order Pharmacy ❑ Specialty Pharmacy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Secondary Pharmacy

Type: ❑ Local Pharmacy ❑ Mail-order Pharmacy ❑ Specialty Pharmacy

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

x _____ x _____
Patient/Guardian Signature *Date*

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