The Clinic for Neurology, P.A.
185 Chateau Drive, Suite 301
Huntsville, AL 35801

Date: _____

INITIALS	OFFICE USE ONLY
ENCOUNTER NO.	

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First	MARITAL (S M W D SEP)	DATE OF BIRTH	AGE	SEX

RACE: ❑ AFRICAN AMERICAN ❑ ASIAN ❑ CAUCASIAN / WHITE ❑ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ❑ AMERICAN INDIAN / ALASKA NATIVE ❑ DECLINED ❑ UNKNOWN

PRIMARY LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER _____	ETHNICITY: ❑ HISPANIC ❑ NON-HISPANIC ❑ DECLINED ❑ UNKNOWN	
ADDRESS	CITY , STATE & ZIP	EMAIL

SOCIAL SECURITY NO.	HOME PHONE NO. ( )	BUSINESS PHONE NO. ( )	CELL PHONE NO. ( )

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	RELIGION (OPTIONAL)

EMPLOYER'S ADDRESS	CITY, STATE & ZIP

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO. ( )

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE	RELATIONSHIP	HOME TELEPHONE NO. ( )	BUSINESS PHONE NO. ( )

ADDRESS	CITY, STATE & ZIP

REFERRING PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )
FAMILY PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

PERSON RESPONSIBLE FOR BILL: _____

IF OTHER THAN PARENT, S.S.# _____

ADDRESS OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
SECONDARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
OTHER INSURANCE	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by The Clinic for Neurology, P.A. for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of The Clinic for Neurology, P.A. or until patient revokes authorization.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for The Clinic for Neurology, P.A. to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original. Authorization is continuing while patient is under care of The Clinic for Neurology, P.A. or until patient revokes authorization.

Signature: _____ Date: _____

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER