SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.
1601 CLINT MOORE ROAD, SUITE 120, BOCA RATON, FL 33487
PH: 561-939-0300 FAX: 561-939-0339

Patient Information Form

Name: _____ Sex: ____ M _____F

Home Phone: _____ Work Phone:_____Cell Phone:_____

Email Address: _____

Home Address: _____ City/State: _____ Zip Code: _____

Patient Social Security #: _____ Date of Birth:_____

Driver's License #: _____ State: _____ Exp. Date: _____

Marital Status: Married Divorced Legally Separated Single

Full Time Student: Yes No Name of School: _____

Nearest relative not living with you: _____ Phone:_____

Nearest friend not living with you: _____ Phone: _____

Emergency contact:_____ Phone:_____

Whom may we thank for referring you to us?_____ Phone:_____

Who is responsible for this bill? _____

Name of referring/primary physician: _____

Did you sustain an injury at work? □Yes □No

Are you covered under an employer or union policy? □Yes □No

Are your injuries accident related? □Yes □No

Is your spouse or other family member employed? □Yes □No

Are you currently employed? □Yes □No

Do you have a secondary insurance policy? □Yes □No

Have you ever served in the military? □Yes □No

Are you covered under any other health care plan? □Yes □No

Have you made any changes to your choice of Medicare options in the last open enrollment period?

Y N

Are you enrolled in a Medicare Advantage Plan?

Y N

I am a new patient to this practice and am in a pre-existing provision with my insurance carrier.

Y N

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Medical Insurance Information:

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____ Policyholder Social Security #: _____

Insurance Carrier Name, Address, Phone #:

_____

_____

Identification card present upon encounter: Yes No

Secondary Medical Insurance

If information is same as the information above indicate with "Same as and indicate which policyholder is applicable" in the appropriate data fields. Leave blank if you do not have a secondary policy.

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____ Policyholder Social Security #: _____

Insurance Carrier Name, Address, Phone #:

_____

_____

Identification card present upon encounter: Yes No

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____

Date: _____