NeuroRehabilitation and Neuropsychological Services, PC
Patient Information Sheet

Please fill out this form **COMPLETELY,** write N/A where applicable and sign it. Thank you.

Referral Source: _____

Do you have Medical Insurance? (Please Check) **Yes** **No** **Patient's Sex**: Male Female

What is your Relationship To Policy Holder? (Please check) **Self** **Spouse** **Other:**_____

Patient Social Security # _____ -- _____ -- _____

Patient Name: (Last) _____ (First) _____(MI)_____

Street Address: _____

City:_____ **State:**_____ **Zip:**_____

Home Telephone ( )_____ **Work Telephone:** ( ) _____

Age: _____ **Patient's Date of Birth:** _____

Are you Married? (Please Check) Yes No

Name of Spouse _____ **Emergency Tel**:_____

Patient's Insurance Information

Primary Insurance Company Information:	**Secondary Insurance Company Information:**
Company Name:_____	Company Name:_____
Address:_____	Address:_____
Insurance#_____	Insurance#_____
Group#_____	Group#_____
Do you have a Co-pay? Yes Amt $_____or NO	Do you have a Co-pay? Yes Amt $_____or NO
Policy Holder Information	**Policy Holder Information**
Name: _____	**Name:** _____
Policy Holders SS# _____-_____-_____	**Policy Holders SS#** _____-_____-_____
Address:_____	Address:_____
City:_____State:_____Zip:_____	City:_____State:_____Zip:_____
Policy Holders Date of Birth: _____	**Policy Holders Date of Birth:** _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY ASSIGN TO NEUROREHABILITATION AND NEUROPSYCHOLOGICAL SERVICES, PC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Patient's Signature: _____ **Today's Date:**_____

Active Management
NeuroRehab – Pt Information Sheet
Revised 05/29/01 HH

Checked by: _____