NEUROLOGY ASSOCIATES OF WESTCHESTER, PLLC

Please print clearly

**Patient Age: _____

Patient: Last Name, First Name: _____

Address: _____ APT #: _____

City: _____State: _____ Zip Code: _____

Home #:_____ Work #: _____Cell #: _____

Patient DOB: _____Patient Sex: M_____ F_____ Marital Status: _____ S____M____D___W___

**Race: _____ ***Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Refuse to Report (Circle One)

***Language: English or Other _____

Patient SS #: xxx-xx-_____ (last 4 digits unless you have "Tricare")

Chief Complaint-Reason for Visit: _____

Email Address: _____

Emergency contact: _____Phone #: _____ Relationship: _____

Employer Name & Address: _____

Primary Care MD: _____ Referring MD: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Fax #: _____ Fax #: _____

Pharmacy Name: _____ Phone #: _____

Address: _____City, State and Zip Code_____

Insurance Information:

Primary INS: _____Policy #: _____ Group #: _____

Phone # _____ Policy Holder name: _____ Holder's DOB: _____

Policy holder SS#: _____ Policy Holder Relation to patient: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Phone # _____Policy Holder name: _____Holder's DOB: _____

Policy holder SS#: _____ Policy Holder Relation to patient: _____

Last Name:_____ **First Name:**_____ **DOB:**_____

********** **Worker's Compensation and No Fault Information:**

Were you injured on the job: Yes_____ NO_____?

Carrier Case #: _____ WCB # _____

Date of Injury: _____

Name of Carrier: _____

Employer's Name: _____

Employer's Address & Phone #: _____

Contact: _____

Attorney Name & Phone #: _____

Were you injured in an Automobile Accident: Yes_____ No _____?

No Fault Case and/or Claim #:_____ File #: _____

Date of Accident: _____

Name of Carrier: _____ Phone #: _____

Policy Holder: _____

Address of Carrier: _____ Contact/ Claim Agent: _____

Attorney Name & Phone #: _____

******** *We require your private insurance information to be on file even if you are a NF or WC patient.*

I hereby authorize Neurology Associates of Westchester, PLLC. to furnish information concerning any illness and treatment to my insurance carriers, and physicians. I authorize payment of medical benefits to NAW and understand that I am completely responsible for any part of the charges that are not covered by medical insurance. I have read and understand the financial policy. There is a fee for all appointments that are not cancelled ***at least 24 hours in advance***. You will be billed based on the type of appointment you have.

Signature: _____

Date: _____

If person other than the patient signs, please indicate relationship to the patient and reason for lack of patients signature in the space below:

_____

Please visit www.Neurologywestchester.com

***** MUST BE COMPLETED AND SIGNED FOR HIPAA RULES AND REGULATIONS