NEUROLOGY CONSULTANTS, P.C.

Pavilion II, 1351 West Central Park, Suite 3300 • Davenport, Iowa 52804
(563) 383-2667 • fax (563) 383-2672

Appointment with
Dr. ______________________
on ______________________
at ______________________

PATIENT INFORMATION

Legal name ______________________

Address ______________________ City ______________________ State __________ Zip __________

Marital Status S M W D Sex M F Social Security number ______________________

Date of Birth ______________________ Home Phone ______________________ Work Phone ______________________

Employer ______________________

Employer address ______________________

Spouse's name ______________________ Spouse's employer ______________________

Parent/legal guardian name ______________________ Parent/legal guardian phone ______________________

Emergency Contact ______________________ Relationship ______________________ Phone ______________________

Referring physician ______________________

INSURANCE

YOU ARE FINANCIALLY RESPONSIBLE FOR PAYMENT. DEDUCTIBLES, CO-INSURANCE, AND CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU WISH US TO SUBMIT YOUR CLAIM TO YOUR INSURANCE CARRIER PLEASE COMPLETE THIS SECTION. WE WILL NEED COPIES OF YOUR INSURANCE CARDS IN ORDER TO FILE A CLAIM ON YOUR BEHALF.

PRIMARY INSURANCE

Company name ______________________ Effective Date ______________________

Policy holder's name ______________________ Policyholder's Date of Birth ______________________

Policy holder's social security number ______________________ Relationship to patient ______________________

Policy # ______________________ Group # ______________________

Policyholder's employer ______________________

Policyholder's employer address ______________________ Employer phone ______________________

SECONDARY INSURANCE

Company name ______________________ Effective Date ______________________

Policy holder's name ______________________ Policyholder's Date of Birth ______________________

Policy holder's social security number ______________________ Relationship to patient ______________________

Policy # ______________________ Group # ______________________

Policyholder's employer ______________________

Policyholder's employer address ______________________ Employer phone ______________________

WORKMAN'S COMP OR LIABILITY

_____ workman's comp _____ auto accident _____ liability

Date of injury ______________________ Briefly describe injury ______________________

____

Insurance company name ______________________ Insurance company phone ______________________

Employer name (if work comp) ______________________ Employer phone ______________________

Employer contact ______________________ Adjustor name ______________________

Billing address ______________________ Claim # ______________________

FINANCIAL AUTHORIZATION ON FILE

I hereby authorize Neurology Consultants, P.C. physicians and staff to render treatment as deemed necessary. I agree to pay any and all charges incurred during treatment, including, but not limited to, charges that exceed or are not covered by my insurance, and attorney or collection costs incurred due to referral of delinquent account to an outside agency.

SIGNATURE ______________________ DATE ______________________

RELATIONSHIP TO PATIENT (IF UNDER 18 YEARS OLD) ______________________