NEUROLOGICAL INSTITUTE OF NEW JERSEY
90 BERGEN STREET, 8TH FLOOR
NEWARK, NJ 07103

PATIENT INFORMATION

CELL PHONE # (____)_____

DATE_____ HOME PHONE # (_____)_____

PATIENT_____
LAST FIRST

RESPONSIBLE PARTY ***(if a minor)***_____
MOTHER'S NAME FATHER'S NAME

ADDRESS_____

_____
CITY STATE ZIP CODE

SEX: M ☐ F ☐ AGE_____BIRTHDATE_____RACE_____RELIGION_____

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ PATIENT SS#_____

PATIENT EMPLOYED BY:***(If a minor, parents please provide your employment information)***

_____

BUSINESS ADDRESS_____

OCCUPATION_____YEARS EMPLOYED_____BUSINESS PHONE _(_____)_____

SPOUSE'S NAME_____
LAST FIRST

EMPLOYED BY:_____

BUSINESS ADDRESS_____

OCCUPATION_____YEARS EMPLOYED_____BUSINESS PHONE _(_____)_____

IN CASE OF EMERGENCY, CONTACT **PHARMACY_____ PHONE_____**

NAME_____RELATIONSHIP TO YOU_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

HOME PHONE # _(_____)_____ BUSINESS PHONE # _(_____)_____

REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN
LAST/FIRST NAME_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

TELEPHONE # _(_____)_____ FAX # _(_____)_____

PRIMARY CARE PHYSICIAN
LAST/FIRST NAME_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

TELEPHONE # _(_____)_____ FAX # _(_____)_____

INSURANCE INFORMATION

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT?_____
LAST/FIRST NAME

RELATIONSHIP TO PATIENT_____SS#_____BIRTHDATE_____

INSURANCE COMPANY_____

MEMBERS ID #_____GROUP #_____

INSURANCE CLAIMS ADDRESS_____

MEMBER CUSTOMER SERVICE # _____

SECONDARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT?_____
LAST/FIRST NAME

RELATIONSHIP TO PATIENT_____SS#_____BIRTHDATE_____

INSURANCE COMPANY_____

MEMBERS ID #_____GROUP #_____

INSURANCE CLAIMS ADDRESS_____

MEMBER CUSTOMER SERVICE # _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and / or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____hereby authorize_____
(Name of Insured) (Name of Insurance)
to pay and hereby assign directly to _____all benefits, if any, otherwise
(Provider's Name)
payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to_____, will be credited to my account, in accordance with
(Provider's Name)
the above said assignment.

_____ _____
(Authorized Signature) (Date)

(OFFICE USE ONLY)

CPI#_____**MED REC#**_____

ATTENDING_____