

PHOENIX NEUROLOGICAL ASSOCIATES, LTD.

BARRY A. HENDIN, M.D. TODD D. LEVINE, M.D. HARRY S. TAMM, M.D.
LORI H. TRAVIS, M.D. DAVID S. SAPERSTEIN, M.D.

PLEASE INFORM US IF YOU HAVE BEEN SEEN BY ANY OF OUR DOCTORS.

PLEASE PRINT CLEARLY AND FILL THIS FORM IN COMPLETELY

PATIENT INFORMATION:

DATE:

NAME: SOCIAL SECURITY #:

HOME ADDRESS: CITY:

STATE: ZIP CODE: HOME PHONE: CELL PHONE:

PLACE OF BIRTH: DATE OF BIRTH: AGE:

MALE FEMALE MARITAL STATUS: RIGHT OR LEFT HANDED:

EMPLOYER: OCCUPATION:

BUSINESS ADDRESS: BUS. PHONE #:

SPOUSE OR PARENTS NAME:

EMPLOYER: BUSINESS PHONE:

NAME OF RELATIVE NOT LIVING WITH YOU:

RELATIONSHIP: PHONE #:

ADDRESS: CITY STATE ZIP

INSURANCE INFORMATION:

INSURANCE COMPANY NAME:

GROUP #: I.D. #: PHONE #:

ADDRESS TO MAIL CLAIMS:

INSURED'S NAME: DATE OF BIRTH:

ADDRESS: PHONE #:

SOCIAL SECURITY #:

EMPLOYER: ADDRESS PHONE #

REFERRING DOCTOR (FULL NAME):

ADDRESS PHONE #

REASON FOR VISIT:

SIGNATURE OF FINANCIALLY RESPONSIBLE PARTY

SIGNED (PATIENT, OR PARENT IF MINOR) DATE

This office may release medical records and/or x-ray films pertaining to my treatment to my insurance company or other third party responsible for payment of my medical charges. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

SIGNED (PATIENT, OR PARENT IF MINOR) DATE