



NEUROLOGICAL SURGERY, P.C.

Benjamin R. Cohen, MD

NAME _____ DOB: ____/____/____ Age: _____

ADDRESS _____ City _____ State _____ Zip _____

TELEPHONE

Residence: _____ Cell: _____ Work: _____ Ext: _____

FEMALE MALE

OCCUPATION _____

EMPLOYER NAME/ADDRESS _____

REFERRED BY: _____

Address: _____ Telephone: _____

PCP: _____

Address: _____ Telephone: _____

Emergency Contact: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID#: _____

Policy Holder's Name: _____ In Network Out of Network

Policy Holder's DOB: _____ Policy Holder's SS#: _____ - _____ - _____

SECONDARY INSURANCE: _____ ID#: _____

Policy Holder's Name: _____ Relationship: _____ In Network Out of Network

DOB: _____ SS#: _____ - _____ - _____ GROUP _____

➔ Please Circle: Worker's Compensation OR No Fault

Insurance Name: _____ DATE OF ACCIDENT: _____

Insurance Address: _____

Policy #: _____ Claim #: _____ Carrier Case #: _____

Case Manager: _____ Telephone: _____

I authorize the release of any medical information necessary to process this claim.

I authorize payment of medical benefits to Neurological Surgery, PC for professional services. I understand that I am responsible for any amount not covered by insurance.

Signature: _____

Date: _____

I acknowledge that I have received a copy of Neurological Surgery P.C.'s "Notice of Privacy Practices" as required by the Health Insurance Portability and Accountability Act of 1996. I understand that the Notice is intended to provide me with general information about Neurological Surgery P.C.'s privacy practices with respect to Individually Identifiable Health Information, and that it is not a contract. I further understand that all of the policies and information contained in the Notice are subject to change by Neurological Surgery, P.C. with or without notice, in accordance with applicable law.

Signature: _____

Date: _____

FOR MD USE ONLY

PATIENT: _____ **DATE:** _____ **DOS:** _____ **STATUS:** _____

MRI: _____

CT SCAN: _____

XRAYS: _____

EMG: _____

LAB WORK: _____

FOLLOW UP APPOINTMENT: _____

OTHER: _____

SURGERY/ADMISSION: _____