Doctor: _____

Neurosurgical Associates, P.C.
800 St. Vincent's Drive
North Tower, Suite 700
Birmingham, Al 35205
Office (205) 933-8981
Fax (205) 930-0746

Date: _____

Chart # _____

Please Fill Out Completely:

Last Name	First Name	MI

Social Security Number	Date of Birth	Age	Cell Phone Number	E-Mail Address

Address (Street, Route, Apt, No., etc.)	City	State	Zip Code

Home Phone Number	Marital Status	Sex	Driver's License Number	Employed By/Occupation/Business Phone

Primary Insured Information:

Name	Address	City	State	Zip Code

Home Phone	Social Security Number	Date of Birth	Relationship to patient

Emergency Contact (Friend or relative not at Patient's address who can get a message to you).	Daytime Phone

Referring Provider	Referring Provider Phone #	Primary Care Provider	Primary Care Provider Phone #

Insurance Information

Is the current condition related to: ☐ Work ☐ MVA ☐ Accident ☐ Other

Date Problem Started: _____

Were you injured on the job: ☐ Yes ☐ No If yes, name of Employer or Company: _____

Worker's Comp or Auto Insurance _____

Claim # _____ Address: _____

Contact Person: _____ Phone/Fax#: _____

Primary Health Insurance Company: _____

Policy # _____ Group#: _____

Insured Name: _____ Date of Birth: _____

Secondary Health Insurance Company: _____

Policy # _____ Group #: _____

Insured Name: _____ Date of Birth: _____

List Any Persons to Whom You Will Allow Access of Your Medical Records

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I further authorize and request that insurance payments be made directly to **Neurosurgical Associates, PC** should they elect to receive such payment. **This is a direct assignment of my rights and benefits under this policy.** A photocopy of this assignment shall be considered as effective and valid as the original. I acknowledge full financial responsibility for services rendered by Neurosurgical Associates PC. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I authorize treatment by Neurosurgical Associates, PC physicians personnel. This authorization shall remain in effect until revoked in writing. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Signature: _____ Signature: _____ Date: _____

Patient Responsible Party