

LYERLY NEUROSURGERY

- Commercial
- Workers Comp
- Auto Accident

Date _____

Patient Information Sheet (Please Print)

Email _____

Referred by _____

Patient's Name _____ Phone # () _____

Address _____ Cell Phone # () _____

City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ Social Security # _____

Circle One Married Single Divorced Separated Widowed

Patient/Parent/Guardian Employer _____ Phone # () _____

Address of Employer _____ Type of work _____

Spouse's Name _____ Employer _____ Phone # () _____

Employer's Address _____ Type of work _____

FIRST INSURANCE _____ Policyholder _____

Address _____

Phone # () _____ Policy # _____ Group # _____

Policyholder's S.S. # _____ Policyholder's Birthdate _____

SECOND INSURANCE _____ Policyholder _____

Address _____

Phone # () _____ Policy # _____ Group # _____

Policyholder's S.S. # _____ Policyholder's Birthdate _____

THIRD INSURANCE _____ Policyholder _____

Address _____

Phone # () _____ Policy # _____ Group # _____

Policyholder's S.S. # _____ Policyholder's Birthdate _____

Nearest Relative NOT LIVING WITH YOU/Relationship _____ Phone # () _____

Address _____

IF YOU HAVE RETAINED AN ATTORNEY, PLEASE GIVE: Name _____

Address _____ Phone # () _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: **LYERLY NEUROSURGERY**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency I will be responsible for collection cost, attorney fees, litigation fees and court costs. I hereby authorize LYERLY NEUROSURGERY and its employees and agents, TO RELEASE ALL INFORMATION, reports and records if necessary to secure the payment of my account, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals and doctors.

Signed (Insured Person) _____ Date _____

Responsible Person if Patient is a Minor _____