BOCA RATON NEUROLOGIC ASSOCIATES

DATE : _____

PATIENT INFORMATION:

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET APT. NUMBER

_____
CITY STATE ZIP CODE

TELEPHONE: (___)_____ (____)_____
HOME CELL

EMAIL: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NO: _____ GENDER: ( ) Male ( ) Female

STATUS ____ Married ___ Single ___ Divorced __ Widowed

SPOUSE'S NAME: _____

REERRING DOCTOR: _____ PRIMARY DOCTOR: _____

Other Specialists You See: _____

Are You Retired? ____ Yes ____ No Occupation(former): _____

Do you have a Living Will or Power of Attorney? ___Yes ___ No, If No, Would you like to receive additional information regarding Living Will or Power of Attorney? ____ Yes ____ No

Who will be your decision make if you become incapacitated?_____

REASON FOR YOUR VISIT: _____

_____

I hereby assign al medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plan to Boca Raton Neurologic Associates, PA (BRNA). This assignment will remain in effect until revoked by us in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:_____ Date: _____

(561) 338-8484 (561) 338-8492 (fax)
Boca Raton Medical Plaza, 1050 NW 15th St., Suite 216A Boca Raton, Florida 33486