Mid-South Physician's LLC/Adult Neurology Information Form

The patient or his/her guardian is responsible for bringing his/her referral for each and every visit.

Bring a copy of your HMO/PPO insurance card, TennCare/Medicaid card or Medicare card.

For insurance purposes, we must have the patient's name as it appears on his or her birth certificate (no nicknames).

Patient's Name: ______________________________

What's their birthdate? ____/____/____ Race______ Sex______ Social Security No. ______-______-______

Address: ______________________ City ______________ St ______ Zip ______________

Home phone: (________) ______________________ Work phone (________) ______________________

Cell phone: (________) ______________________ e-mail address: ______________________

Employer: ______________________ Occupation: ______________________

Employer's Address: ______________________________

Who can we contact in an emergency? ______________________ Phone (______) ______________________

Who is responsible for the bill? ______________________ Their birthdate: ____/____/____

How are they related to the patient? ______________________ Social Security No. ______-______-______

What is the responsible party's **billing** address? ______________________ Employer: ______________________

Primary care doctor ______________________ Phone (______) ______________________

Primary Doctor's address: ______________________________

Referring doctor ______________________ Phone (______) ______________________

Referring Doctor's address: ______________________________

Insurance Information

We file many different insurance plans. It is the patient's responsibility to verify our participation in his/her plan. **Tell us if your insurance requires specific facilities for lab work, EEG, CT, MRI, <u>etc</u>.** We cannot be responsible if care/testing is done at a non-provider facility.

Hospital you use for testing: ______________________ Lab for blood work: ______________________

Primary Insurance: ______________________ Employer: ______________________

Insurance's address: ______________________ Insurance's phone: (______) ______________________

Insurance/Medicaid number: ______________________ Group: ____________ Effective date: ____/____/____

Under whose name is this insurance? ______________________ Phone: (________) ______________________

Their address: ______________________________

Secondary Insurance ______________________ Employer: ______________________

Insurance's address: ______________________ Insurance's phone: (______) ______________________

Insurance/Medicaid number: ______________________ Group: ____________ Effective date: ____/____/____

Under whose name is this insurance? ______________________ Phone: (________) ______________________

Their address: ______________________________

Who completed this form? ______________________ **Today's Date:** ____/____/____

Is this office visit for an accident related episode or workman's compensation? ______________________