

Dr. Miric Neurology Center

PATIENT INFORMATION: (Please Print)

Today's Date: ___/___/___

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: ___/___/___ Age: _____ Sex: _____ Marital Status: _____

 Employment Status: Employed Retired Unemployed Occupation: _____

Employer: _____ Work Phone: _____

Employer Address: _____

PARENT/RESPONSIBLE PARTY (if different from patient)

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION/POLICY HOLDER: Do you have insurance? Yes No

Primary Insurance: _____ Subscriber ID #: _____

 Group #: _____ *Name of Cardholder:* _____

Date of Birth: ___/___/___ SS #: _____

Secondary Insurance: _____ Subscriber ID #: _____

 Group #: _____ *Name of Cardholder:* _____

Date of Birth: ___/___/___ SS #: _____

OTHER INFORMATION:

Referred by: _____ Primary Care Physician: _____

Pharmacy of choice: _____ Phone: _____

Do we have your permission to:

 Leave a message on your answering machine at home? Yes No

 Leave a message at your place of employment? Yes No

 Discuss your medical condition with any member of your household? Yes No

In case of Emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: _____

***** **TURN OVER PAGE AND SIGN FORM PLEASE** *****

ASSIGNMENT OF BENEFITS:

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled. This includes Medicare, private insurance, and other health plans to Slobodan, Miric, MD. 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. I hereby authorize the release of all of my medical records from other physicians and institutions in order that I may be given the appropriate care.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services (CMS, formerly HCFA) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place to the original signed assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128B of the Social Security Act and 31U.S.C.3801-3812 provides penalties for withholding this information.) We will file all claims as a courtesy to you and your insurance company(s) and all necessary documentation for claim processing.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I wish to place the following restrictions on disclosure of my health information:

Patient or Responsible Party Signature

Date Signed

INTERNAL USE ONLY

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____