



Patient Information

Name Last Name First Name Initial Soc Sec. #

Address

City State ZIP

Home phone: Work Phone: Cell Phone/Pager:

May we call you at work regarding appointment changes? Yes No

Sex M F Age Birthdate Single Married Widowed Separated Divorced

Referring Physician: Referring Physician Phone:

Family Physician: Family Physician Phone:

Patient Employed By Occupation

Business Address Business Phone

In case of an emergency, who should be notified?

Relationship: Phone

Who may we thank for referring you to our practice?

Was this related to an accident? Yes No Date of accident:

What type of accident? WC Auto Other

Primary Insurance:

Insured Insured's DOB:

Employer

Relation to Patient Insured's Soc. Sec #

Additional Insurance:

Insured Insured's DOB:

Employer

Relation to Patient Insured's Soc. Sec #

Assignment and Release

I, the undersigned, certify that I (or my dependents) have insurance coverage as noted above and assign all insurance benefits, otherwise payable to me for services rendered, payable directly to Abay Neuroscience Center (ANC). I understand that I am financially responsible for all charges whether or not they are paid by any insurance plan I participate in. Further, I understand that if I fail to pay for my charges and ANC refers my account to an outside attorney or collection agency, I am also responsible for all collection fees that an outside attorney or collection agency may charge to collect the charges I owe. I hereby authorize ANC to release all information necessary to secure payment for services they provide me (or my dependents). I authorize the use of my signature on all insurance submissions. I authorize ANC to release my (or my dependents) medical records to my referring, primary and treating physicians and diagnostic centers.

Responsible Party Signature

Relationship, if not the patient

Date

If patient is a child or minor, please complete the back of this sheet.

If you are the parent or responsible guardian to the patient, please complete the following about yourself:

Your Name \_\_\_\_\_

Your Address \_\_\_\_\_

Your City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Your Relationship to the Patient: Parent / Guardian / Other (Please explain): \_\_\_\_\_

\_\_\_\_\_

Your Social Security Number \_\_\_\_\_

Your Date of Birth \_\_\_\_\_

Your Phone Number(s): Home \_\_\_\_\_ Cell \_\_\_\_\_

Additional Information: \_\_\_\_\_

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I, as the responsible party, certify that the above information is correct to the best of my knowledge. I will not hold my physician or any members of their staff responsible for errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_ Responsible Party Signature

\_\_\_\_\_ Date



**ABAY NEUROSCIENCE CENTER** 3223 N. Webb Rd., Ste. 1 • Wichita, KS 67226 • Ph 316-609-2600 • Fax 316-609-2800