WEST INDIAN NEUROSCIENCES

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New Patient Information

West Indian Neurosciences Location _____

How did you hear about us? (Circle one) Doctor Referral WIN Website Yellow Pages Friend Other _____

Name: *Last* _____ *First* _____ *MI* ____

Address:_____ City:_____ Country: _____

Phone Number (Home):_____ Phone Number (Cell): _____

Email Address: _____

Date of Birth _____Age _____ ☐ Male ☐ Female

ID Number: _____

Employer: _____ Occupation: _____

Do you have a Living Will? _____
Do you have a Power of Attorney?____ If yes, list their name and Number: _____

Emergency Contact:
Name:_____

Address:_____ City:_____ ST:____ Zip:_____

Phone #: _____ Cell Phone:_____ Relationship to Patient_____

Do you have insurance? ☐ Yes ☐ No

Insurance:_____

Address:_____

Phone Number:_____ Fax Number:_____

Group #:_____ Policy #:_____

Adjustor Name: _____ Phone Number: _____ Email Address: _____

I authorize the release of any medical information necessary to process an insurance claim for services rendered to me. I also authorize payment of medical benefits directly to West Indian Neurosciences for services rendered to me. I accept full responsibility for my bill if my insurance carrier does not pay.

Date:_____ Patient Signature: _____