Welcome to Southern California Neurology Consultants

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Appointment Date: _____ Time: _____ ☐ A.M. ☐ P.M.

Attached Forms:

- ☐ Medicare Patient Information Form (Below)
- ☐ Patient Registration Record
- ☐ Medical History
- ☐ Notice of Privacy Practices & Private Practices Acknowledgement (***Please read and sign form***)

- **Please complete all forms prior to your office visit.**
- **Please bring your insurance cards and identification card.**
- **If unable to keep this appointment, kindly give us a 24 hours notice.**

MEDICARE PATIENT INFORMATION FORM

Name: _____ Birth date: _____

Who is responsible for this bill? _____

Did you sustain an injury at work? ☐ **Y** ☐ **N**

Are your injuries accident related? ☐ **Y** ☐ **N**

Are you currently employed? ☐ **Y** ☐ **N**

Is your spouse or other family member employed? ☐ **Y** ☐ **N**

Are you covered under an employer or union policy? ☐ **Y** ☐ **N**

Do you have a secondary insurance policy? ☐ **Y** ☐ **N**

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature ***Date***