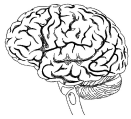

PATIENT INFORMATION

Neurology Consults, P.C.
Teresa Zyglewska M.D., Ph.D.
300 Stonecrest Blvd, Suite 260
Smyrna, TN 37167

Thank you for choosing our office. In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Patient Name: _____ Age: _____
Last First M.I

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Other Phone: _____

SSN: _____ - _____ - _____ Birth Date: _____ ☐ Male ☐ Female

E-mail address: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Patient's Employer: _____

Referring Physician: _____ Office Phone: _____

Person to contact in case of emergency: _____ Phone: _____

Insurance Information:

Primary Insurance Company: _____ ☐ HMO ☐ PPO
copy of the card required

Secondary Insurance Company: _____
copy of the card required

Do you have additional insurance? ☐ Yes ☐ No Other Insurance: _____

AUTHORIZATION:

I authorize payment of medical benefits to my physician in the event she files insurance for services rendered.
I understand I am financially responsible for all charges whether or not paid by insurance. Past due balance is subject to 2.00 % interest. Cancellation policy: We charge $50 for no show, or $ 25 for less than 24 hour notice. In the event my account is placed with an outside agency for collection, I agree to pay all collection cost, court cost and attorney fees incurred to collect my account.

Signature: _____ Date: _____
Patient or or Patient's legal representative

OVER ⇨

Printed name of patient's legal representative: _____

Relationship to the patient: _____