ARIEL F.ABUD MD LLC
NEUROLOGICAL SURGERY

Patient Information Sheet **Date**: _____

******PATIENT INFORMATION******

Patient Name:_____ Home Phone:( )_____

Address:_____

City:_____ State:_____ Zip:_____ DOB: _____/_____/_____

Sex: M F Marital Status: S M W D Separated Social Sec. #:_____-_____-_____

Cell Phone: ( )_____ Email Address:_____

Employer:_____ Work Phone:( )_____

Work Address:_____ City:_____ State:_____ Zip:_____

Pharmacy Name/Phone #:_____ Spouse/Partner:_____

Referred by:_____ Primary Care Physician:_____

Parent/Guardian: (person to be billed if patient is under age 18)

Name:_____ Home Phone:( )_____

Address:_____

City:_____ State:_____ Zip:_____

DOB:_____/_____/_____ Social Sec. #:_____-_____-_____

Employer:_____ Work Phone:( )_____

Work Address:_____ City:_____ State:_____ Zip:_____

******MEDICAL INSURANCE INFORMATION******

Primary Insurance Company:_____ Group #_____

Policy/ID #_____ Patient Relationship to Subscriber:_____

Subscriber's Name:_____ DOB:_____ S.S.#_____

Secondary Insurance Company:_____ Group #_____

Policy/ID #_____ Patient Relationship to Subscriber:_____

Subscriber's Name:_____ DOB:_____ S.S.#_____

Other Insurance(s)?:_____

Subscriber Information:(if different from patient or parent/guardian) _____ Primary _____ Secondary

Address:_____

City:_____ State:_____ Zip:_____

Employer:_____ Work Phone:( )_____

Work Address:_____ City:_____ State:_____ Zip:_____

In Case of Emergency, Contact: _____ Relationship:_____

Home Phone:_____ Work Phone:_____ Other:_____

Please read, sign and date below to allow us to bill your insurance company for your medical care:

I have completed this form and certify that I am the Patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I might have some type of insurance coverage, I am responsible for payment for services. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by ARIEL F ABUD MD, LLC required to substantiate or explain insurance claims filed, and I authorize payments directly to ARIEL F ABUD MD, LLC and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

If I have Medicare coverage, I request that payment of authorized Medicare benefits be made either to me or on my behalf to ARIEL F ABUD MD, LLC for any services furnished to me by that physician or supplier. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to ARIEL F ABUD MD, LLC for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to:

_____

(Name of Medigap Insurer)

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE

****

I have read and reviewed the above information, and there are no changes to the information provided.

(to be re-signed once a year)

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____