MIDDLE TENNESSEE NEUROLOGY

Responsible Party	
Name	
Address	
Phone	
Birth Date	
Social Security Number	
Patient Information	
Name	
Address	
Phone	
Cell Phone	
Email Address	
Birth Date	
Sex	
Marital Status	
Age	
Social Security #	
Emergency Name	
Emergency Phone	

Section must be completed:

1) **Race:** ❑ White ❑ Black or African American ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or other Pacific Islander ❑ Unreported/Refused to Report
2) **Ethnicity (Cultural Background):** ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Refused to Report
3) **Language:** ❑ English; ❑ Spanish; ❑ Indian; ❑ Japanese; ❑ Chinese; ❑ Korean; ❑ French; ❑ German; ❑ Russian; ❑ Other _____

Health Insurance	
Name of Insured	
Patient Relationship to Insured	
Birth Date	
Primary Insurance Company	
Primary Claim Address	
Primary Phone	
Primary Policyholder	
Primary Subscriber #	
Primary Group #	
Primary Insurance Copay	
Specialty Insurance Copay	
Secondary Insurance Company	
Secondary Subscriber #	
Secondary Group #	
Pharmacy Name	
Pharmacy Phone#	

How did you hear about us?

❑ Referring Provider ❑ Website ❑ HealthGrades.com ❑ Family/Friends ❑ Blog
❑ Search Engine ❑ Facebook ❑ Yelp.com ❑ Physician Directory ❑ Twitter
❑ Google Places Page ❑ Vitals.com ❑ Other

I certify the above demographic and insurance information listed above to be correct. I hereby authorize any insurance benefits to be paid directly to the physician providing services and recognize my responsibility to pay for all non-covered services. I also authorize the physician to release any information necessary to process an insurance claim.

X	Date