

**Collier Neurologic Specialists Patient Information Form**

Doctor: Baker Campbell Colon Dernbach Justiz Rabbani Santiago Testing Krueger  
(Please circle)

Referring Physician: \_\_\_\_\_ New \_\_\_\_\_ Est \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ SS# \_ \_ - \_ - \_ \_ \_ M or F

Local Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Northern Address \_\_\_\_\_ Cell ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_

Employer \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Ext \_\_\_\_\_

\*Primary Insurance Name \_\_\_\_\_ Insured Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Date of Accident \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured SS # \_ \_ - \_ - \_ \_ \_ Relation to Patient \_\_\_\_\_

\*Secondary Insurance Name \_\_\_\_\_ Insured Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Date of Accident \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured SS # \_ \_ - \_ - \_ \_ \_ Relation to Patient \_\_\_\_\_

Have you had an MRI or other similar tests done? If "YES", please list what and where below.

Test(s) \_\_\_\_\_ When \_\_\_\_\_

*Payment is expected at the **TIME OF SERVICE** unless other arrangements have been made with the Billing Department prior to the appointment. If we participate with your insurance carrier any deductible and/or co-insurance will be due at the time of service. If no payment is received from your insurance carrier after 45 days from the filing date, the balance will become your responsibility.*

**Consent For Treatment:** I the undersigned, whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physician.

Patient / Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

