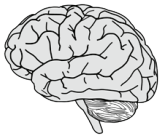

Tennessee Valley Neurological Associates

PLEASE PRINT **(Please use Black or Blue Ink ONLY)** **Patient Information Form**

Patient Name:_____ Date: _____

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

Referring Physician: _____ Family Physician: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone ( ) _____ Ext. _____ Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Letter

SS#: _____ - _____ - _____ Sex: M or F Age:_____ Date of Birth:_____ /_____/_____

☐Married ☐Divorced ☐Separated ☐Widowed ☐Single Preferred Language _____ Email: _____

Patient's Employer:_____ Occupation: _____

Employer's Address: _____

(Please provide Account Guarantor's Information, when the patient is a minor)

Spouse or Account Guarantor's Name: _____ Date of Birth:_____ / _____ /_____

SS#: _____ - _____ - _____ Occupation: _____

Employer: _____ Phone: ( ) _____

Notify In Case of Emergency: _____ Relationship:_____

Phone: ( ) _____ Cell Phone: ( ) _____

Notify In Case of Emergency: _____ Relationship:_____

Phone: ( ) _____ Cell Phone: ( ) _____

Result of on the job injury:_____ **Result of Accident:** _____ **Date of Injury:** _____

(Provide Guarantor's Information only when patient is a minor otherwise provide patient's information) PRIMARY INSURANCE

Insurance Name:	Relationship to Patient:
Subscriber's Name:	Copay Amount:
Subscriber ID/Contract/Policy#:	Group#:
Subscriber's Social Security#:	Subscriber's Date of Birth:
Subscriber's Employer:	Employer's Phone:

SECONDARY INSURANCE

Insurance Name:	Relationship to Patient:
Subscriber's Name:	Copay Amount:
Subscriber ID/Contract/Policy#:	Group#:
Subscriber's Social Security#:	Subscriber's Date of Birth:
Subscriber's Employer:	Employer's Phone:

PERSON RESONSIBLE FOR THIS ACCOUNT _____ Phone: ( ) _____

When applicable, I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs, or attorney's fees. I authorize Huntsville Hospital Neurological Associates to release information to insurance carriers and for insurance carrier's to release information to Huntsville Hospital Neurological Associates concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignments applies.

Signature of Responsible Person _____ **Date** _____ **Time:** _____