NEUROLOGY ASSOCIATES OF SANTA BARBARA

Last Name ______ **First Name** ______ **Middle Initial** ______ **Preferred of Nickname** ______

Maiden Name ______ **Mr. Ms. Mrs. Miss. Dr. Prefix (please select)** **Date of Birth** ____/_____/______ **Sex** ______ **Social Security No.** ______

Marital Status (Select One) ____M__S__W__D **Driver's License #** ______________________

Address:______________________ **City, State** ______________________**Zip:**__________

Home #:______________________ **Work#:** ______________________ **Cell#:** ______________________

Email: ______________________ **Employer** ______________________

Referring Provider: ______________________ **Primary Care Doctor** ______________________

Emergency Contact: ______________________ **Ph#** ______________ **Relationship** ______________

Race (select one)		**Ethnicity (select one)**	**Preferred Communication**	
American Indian/Alaska Native	Declined	Declined	Email	Patient Portal
Asian	Other Race	Hispanic/Latino	Fax	Home Phone
Black/African American	White	Not Hispanic/Latino	Mail	Cell Phone
Nat Hawaiian/Pacific Islander	Unknown	Unknown		

Preferred Pharmacy: ______________________ Pharmacy Phone#: ______________________
Address: ______________________ City: ______________________

Primary Ins: ______________________ Policy ID#: ______________________ Group#: ______________
Policy Holder: ______________________ Policy Holder Relationship: ______________________

Secondary Ins: ______________________ Policy ID#: ______________________ Group#:____________
Policy Holder: ______________________ Policy Holder Relationship: ______________________

If another party is to be billed please provider the following information:
Responsible Party: ______________________ Social Security #: ______________________
Address: ______________________ Relationship: ______________________
City:______________________ State: _____ Zip: ______________________

Injury Information: Work Comp ❑ **Personal** ❑ **Date of Injury:** ______________________
Claim#: ______________ Adjuster Name: ______________ Phone #: ______________________
Insurance Co: ______________________ Address: ______________________
City: ______________________ State: _____ Zip: ______________________

Did you report it to your employer? **Yes** ❑ **No** ❑
Is this a contested claim? **Yes** ❑ **No** ❑

Signature: ______________________ **Date**: ______________________