

NEUROLOGY ASSOCIATES OF SANTA BARBARA

Last Name _____ **First Name** _____ **Middle Initial** _____ **Preferred of Nickname** _____
 _____ **Mr. Ms. Mrs. Miss. Dr.** _____/_____/_____
Maiden Name _____ **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:** _____