SUNRISE NEUROLOGY P.A.
38156 MEDICAL CENTER AVE
ZEPHYRHILLS, FL 33540

PATIENT INFORMATION:

NAME:_____ SOCIAL SECURITY NO:_____

DATE OF BIRTH:_____ MALE:_____ _____FEMALE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

PHONE NUMBER HOME:_____WORK:_____ CELL:_____

MARTIAL STATUS: SINGLE:_____ MARRIED:_____ DIVORCED:_____ WIDOWED:_____

EMAIL ADDRESS:_____

GUARANTOR NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

SOCIAL SECURITY NO:_____ HOME NUMBER:_____

EMPLOYER:_____ WORK NUMBER:_____

EMERGENCY CONTACT:_____ PHONE NUMBER:_____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____

MEMBER ID NUMBER:_____ GROUP NO:_____

PLOCY HOLDER NAME:_____

SECONDARY SUPPLEMENT INSURANCE NAME:_____

MEMBER ID NUMBER:_____ GROUP NO:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN,TRANSFER AND SET OVER TO SUNRISE NEUROLGY P.A./DR.P PATEL ALL MY RIGHTS,TITLE, AND INTEREST TO MY MEDICAL REIMBURSEMENT BENEFITS UNDER MY INSURANCE POLICY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NEDED TO DETERMINE THESE BENEFITS. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL WRITTEN NOTICE IS GIVEN BY ME REVOKING SAID AUTHORIZATION. I UNDERSTANT THAT I AM FINACIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE.

PATIENT'S SIGNATURE:_____ **DATE:** _____

NORTH RESIDENT ONLY

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____