INDIANAPOLIS **neurosurgical** GROUP
Comprehensive Care of the Brain and Spine

CONFIDENTIAL

PLEASE PRINT

Appointment Date:____________________ING Doctor/Provider:______________________________

Patient's Name:____Birthdate:______________
(LAST) (FIRST) (INITIAL)

Home Address:____
(STREET / RR BOX #) (CITY / STATE) (ZIP)

Home Phone:_________________Work Phone:_________________Cell Phone:__________________

Patient's Employer:_________________________________Social Security #:____________________

Please Circle One: Single Married Divorced Separated Widowed Male/Female

Name of Spouse:_____________________________________Spouse's Birthdate:_______________

Spouse's Social Security #:____________________

Spouse's Employer:________________________________Spouse's Work Phone:_______________

If patient is a child: (Responsible Party Information)

Name of Responsible Party:________________________________Social Security #:_____________

Responsible Party's Relationship to Patient:____

Responsible Party's Address:____
(STREET / RR BOX #) (CITY / STATE) (ZIP)

Responsible Party's Home Phone:_____________Responsible Party's Work Phone:_______________

Please indicate below patient's nearest relative or friend not living with the patient.

Name:___________________________________Relationship to patient:________________________

Address:____

Home Phone:_________________Work Phone:_________________Cell Phone:__________________

Referring Physician Information:

Name of Referring Physician:____MD DO OD DC

Referring Physician Address:____________________________________Phone:________________

Family Physician Information:

Name of Family Physician:____MD DO OD DC

Family Physician's Address:____________________________________Phone:________________

Accident/Injury Information:

Injured in a non-work accident?_____Type of accident: Auto___Other___Date of accident:___________

Is a lawsuit involved or contemplated? YES / NO

If yes, name of attorney and phone:____

Worker's Compensation Information:

Is this a worker's comp. injury? YES / NO Date of Injury:_______________________

Employer's Worker's Comp. Carrier Name:____

Address:____Phone:______________________

City/State:______________________________________Zip:____________Claim#________________

Case Manager Name:______________________Phone:___________________Fax:________________

Insurance Information:

Primary Insurance Company Name:____

Primary Insurance Policy Holder Name:__________________Relationship to patient:_______________

Policy Holder Social Security #:_______________________Birthdate:__________________________

Policy/Group Number:____

Policy Holder Employer:____

Second Ins. Co. Name:____Phone:____________________

Insured's Name:____________________Relationship to patient:_____________Birthdate:___________

Employer:____

I hereby authorize the physicians and/or employees of Indianapolis Neurosurgical Group, Inc. to release any current reports or information acquired in the course of my examination or treatment by them to my family physician and referring physician(s). This authorization will remain in force for sixty (60) days from the date signed unless revoked in writing, (IN Code 16-4-8) (1-11)

I authorize and request insurance companies to pay directly to the Indianapolis Neurosurgical Group, Inc., the surgical and/or medical benefits, if any, otherwise payable to me for their services, but not to exceed the charges for those services.

Attorney fees and court costs incurred by Indianapolis Neurosurgical Group, Inc. in the collection of your account balance will be your responsibility.

Signed:____Date:_________________
(BY PATIENT / PARENT / LEGAL GUARDIAN)*

***NOTE: This authorization MUST be signed and dated by the patient unless a minor or has legal guardian; then parent or legal guardian must sign and date.**