BAY AREA NEUROSURGERY, P.A.
813 S. Parsons Avenue
Brandon, FL 33511

PATIENT'S NAME: ____
Last First MI

ADDRESS: ____

CITY: ____________________ **STATE:** ______________ **ZIP:** ____________

***Email address:**____

Home Phone#:__________________**Work Phone#:**______________ **Cell#:**________________

Social Security#: ______________ **Date of Birth:** __________ **Age:** _____ **Male** __ **Female** ___

Whom may we thank for referring you today? ____________________ **Phone #:** ____________

Primary Care Doctor: ______________________ **Phone #:** ______________________

Employer: __________________________ **Address:** ________________________

SPOUSE/NEXT OF KIN/NOTIFY IN CASE OF EMERGENCY

Last Name: ________________________ **First Name:** ________________________

Relationship: ______________________ **Phone Number:** ______________________
INSURANCE INFORMATION
Medical
Primary Insurance: ____

Subscriber ID# ______________________ **GROUP#:** __________________________

Subscriber (If different from patient): ______________ **DOB:** __________ **SSN:** ____________

Secondary Insurance: ____

Subscriber (If different from patient): ______________ **DOB:** __________ **SSN:** ____________

Subscriber ID#:______________________ **GROUP#:** __________________________
Other Claim: **Workers Comp Claim:Yes** ___ **No** ___ **Auto Accident: Yes** ___ **No** ____

Adjustor: __________________ **Phone #:**________________**Date of Injury:** ____________

Address for claims:____

Claim # ____

Authorization and Release:
I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to the third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group, insurance benefits otherwise payable to me. If payment is made to me, I agree to pay BAN the amount paid to me. I understand that my insurance carrier may pay less than the contracted rate for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at the allowable rate. If I am not effective on my insurance at the time of service, I agree to pay 100% of the BAN bill rate.

SIGNATURE: __________________________ **DATE:** ____________________

Caution: Bay Area Neurosurgery is unable to guarantee the security of information passed

via e-mail.