The Nerve and Muscle Center of Texas

DEMOGRAPHIC INFORMATION FORM

(Please Print Clearly)

Today's Date:	PCP:

PATIENT INFORMATION

PATIENT'S LAST NAME:	FIRST:	MIDDLE:	BIRTH DATE:	SEX:	SOCIAL SECURITY NO.:

MAILING ADDRESS STREET	CITY	STATE	ZIP

HOME PHONE: ( )	CELL PHONE: ( )	MARITAL STATUS: SINGLE ☐ MAR ☐ DIV ☐ SEP ☐ WID ☐

SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	SPOUSE'S CELL PHONE ( )

PATIENTS EMPLOYER	SPOUSE'S EMPLOYER
PATIENTS BUSINESS ADDRESS	SPOUSE'S BUSINESS ADDRESS
CITY, STATE, AND ZIP	CITY, STATE, AND ZIP
PATIENTS BUSINESS PHONE ( )	SPOUSE'S BUSINESS PHONE ( )

WHO REFERRED YOU TO OUR CENTER (PLEASE CHECK ONE BOX):	☐ DR.	DR'S PHONE ( )
DR'S ADDRESS:		☐ INTERNET

☐ FAMILY	☐ FRIEND	☐ CLOSE TO HOME/WORK	☐ HOSPITAL	☐ OTHER

OTHER FAMILY MEMBERS SEEN HERE:

IN CASE OF EMERGENCY

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS):	RELATIONSHIP TO PATIENT:	HOME PHONE NO.: ( )	WORK PHONE NO.: ( )
ADDRESS	CITY	STATE	ZIP

I hereby consent to treatment. I authorize HOUSTON NEUROCARE, P.A. to release all medical information (including but not limited to, psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third party payors. I authorize HOUSTON NEUROCARE, P,A., to release all medical information to my referring physician and my primary (family) physician. I authorize HOUSTON NEUROCARE, P.A. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrators to release such information to HOUSTON NEUROCARE, P.A. I agree that these provisions will remain in effect until I provide written revocation to HOUSTON NEUROCARE, P.A. I assign benefits payable to HOUSTON NEUROCARE, P.A. for medical services rendered to myself and/or dependents. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Patient/Guardian signature ____________________ *Date* ____________