EPILEPSY INSTITUTE OF NORTH CAROLINA

Patient Information Sheet / Application for Treatment

Date: ____ /____ / 20_____ **CHART #_____**

PATIENT INFORMATION

LAST _____ FIRST_____ M.I. _____ SEX ☐ M ☐ F

ADDRESS _____ APT #_____ PO BOX _____

CITY _____ STATE _____ ZIP CODE _____

DOB ____/____/_____ AGE _____ SS #_____-_____-_____ DRIVER LICENSE # _____

RACE _____ ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Decline PRIMARY LANGUAGE _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated STUDENT: ☐ FT ☐ PT ☐ N/A

CONTACT INFORMATION

CELL (_____) _____ - _____ * HOME (_____) _____ - _____ WORK (_____) _____ - _____

* *Appointment reminders will be sent to your mobile/cell number via text.* EMAIL _____

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ N/A

EMPLOYER _____ POSITION _____

EMPLOYMENT ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HEALTHCARE PROVIDERS

PRIMARY CARE PHYSICIAN _____ PHONE (_____) _____ - _____

ADDRESS _____ FAX (_____) _____ - _____

CITY _____ STATE _____ ZIP CODE _____

REFERRING PHYSICIAN _____ PHONE (_____) _____ - _____

ADDRESS _____ FAX (_____) _____ - _____

CITY _____ STATE _____ ZIP CODE _____

SPOUSE/PARENT/GUARDIAN

Are you the financially responsible party ? ☐ YES ☐NO *Check one:* ☐ Spouse ☐ Parent ☐ Guardian_____

LAST _____ FIRST_____ M.I. _____ SEX ☐ M ☐ F

ADDRESS _____ APT #_____ PO BOX _____

CITY _____ STATE _____ ZIP CODE _____

CELL (_____) _____ - _____ * HOME (_____) _____ - _____ WORK (_____) _____ - _____

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DOB ____/____/_____ AGE _____ SS #_____-_____-_____ DRIVER LICENSE # _____

RACE _____ ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Decline PRIMARY LANGUAGE _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated STUDENT: ☐ FT ☐ PT ☐ N/A

EMPLOYMENT STATUS: ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ N/A

EMPLOYER _____ POSITION _____

EMPLOYMENT ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

EMERGENCY CONTACT

NAME _____ Relation to patient:_____

PHONE (_____) _____ - _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

INSURANCE INFORMATION

Primary Insurance carrier:_____ Policy # _____

Group # _____ Effective date:____/____/_____ Employer:_____

Address:_____

Guarantor Name (Name insurance is in) Last _____ First _____ M.I_____ DOB ____/____/_____

Guarantor Address:_____ Relationship to patient: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance carrier:_____ Policy # _____

Group # _____ Effective date:____/____/_____ Employer:_____

Address:_____

Guarantor Name (Name insurance is in) Last _____ First _____ M.I_____ DOB ____/____/_____

Guarantor Address:_____ Relationship to patient: ☐ Self ☐ Spouse ☐ Child

COMPLETE THE BACK OF THIS FORM ALSO

EPILEPSY INSTITUTE OF NORTH CAROLINA

Patient Information Sheet / Application For Treatment

CONSENT FOR TREATMENT

My signature below indicates my consent for treatment as prescribed by the ***EPILEPSY INSTITUTE OF NORTH CAROLINA***.

Signed: _____ Date: _____

(If minor - parent or guardian signature)

AUTHORIZATION RELEASE OF INFORMATION

I hereby authorize the release of any information in the course of my examination and/or treatment to the following:

1. My insurance company for reimbursement purposes.
2. My referring physician.
3. My employer if work related only.

Signed: _____ Date: _____

(If minor - parent or guardian signature)

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits to the ***EPILEPSY INSTITUTE OF NORTH CAROLINA***. I also understand that I will be expected to pay the co-payments or deductibles at time of service rendered. I further agree to pay any amounts not covered by my insurance company(s). I understand that it is my *responsibility* to pay any unpaid balance to my account if payment is denied for any reason by my insurance company(s) or workman's compensation. *The patient (or responsible party) remains responsible for this account, not the insurance carrier.*

Method of payment for today's charges: □ *Cash* □ *Check* □ *Credit Card*

Signed: _____ Date: _____

(If minor - parent or guardian signature)

OFFICE USE ONLY

_____

_____