NY Neurological Associates, P.C.

PATIENT DEMOGRAPHICS

Patient's Name (Last, First)		Date of Birth		Age	
Gender	☐ MALE ☐ FEMALE (please Circle)	Social Sec #			
Street Address				Apt #	
City, State, Zip					
Cell Phone (required)		Home phone			
E-Mail (required)		Work phone			
Race/ethnicity (optional)	☐ White/Caucasian	☐ Black/African-American	☐ Asian	☐ Latino/Hispanic	☐ Mixed race/ ethnicity ☐ Declined

EMERGENCY CONTACT

Name	Phone
Home Address	Relationship

PATIENT PORTAL: We encourage all of our patients to join our patient portal. Our portal includes secure e-mail communication with our office, self-scheduling of appointments, request of refills, and review of results.

Do you consent to join our patient portal? ☐ YES ☐ NO

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REFERRING PROVIDER: who referred you to see us?
Name
Phone
Address

PRIMARY DOCTOR (if not the same as your referring doctor)
Name
Phone
Address

PREFERRED PHARMACY INFORMATION (REQUIRED)

Name	Address	Phone

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co. Name:	Insurance Co. Name:
Insurance ID	Insurance ID
Name of Insured	Name of Insured
Insured DOB	Insured DOB
Insured SS#:	Insured SS#:

GUARANTOR INFORMATION

Name	Home Phone
Home Address	Alternate Phone

EMPLOYER INFORMATION

Employer	Address
Occupation	
Phone	

Is your visit today the result of a car accident or injury on the job? Yes☐ No☐

Signed:_____ **Date:** _____