Lake Norman Neurology
Piedmont HealthCare

PATIENT INFORMATION SHEET

Patient name: _____
(first) (middle) (last) (date of birth)

Patient Address_____ Home Telephone# _____

Mobile Telephone# _____

_____

Emergency Telephone# _____

Social Security:_____ Name &Relationship_____

Patient Sex: Male Female Patient Marital Status: Married Single Other

Email Address: _____

Primary Care Physician: _____ Referring Physician:_____

PHARMACY NAME & LOCATION: _____

Reminder calls /Test result calls Preference please circle: Cell Home

May we leave a message: Yes No

Insurance: _____ ID#_____

Insurance Holders Name: _____
(first) (middle) (last) (date of birth)

Insurance Holders Address: _____Phone: _____

_____Patient Relationship: Self – Spouse – Child – Other

Insurance Holders Employer: _____ Employer Phone:_____

Employers Address:_____

I hereby authorize Piedmont HealthCare to release information concerning my medical or surgical treatment to any insurance carrier, including Medicare and Medicaid. I further authorize payment being made directly to Piedmont HealthCare for my insurance benefits including major medical insurance. I understand that I am financially responsible to PHC for my charges and that the filing of insurance does not relieve me of this obligation. I further authorize any payment made by insurance companies that are incorrect to be refunded to the insurance company. I consent to x-ray examinations, laboratory procedures and other medical treatment as recommended by my physician as provided by authorized personnel of Piedmont HealthCare. I also understand that Piedmont HealthCare is not responsible for any of my personal or valuable items I bring with me.

Signature (seal) _____ Date:_____