Patient Information Form

Charlottesville Neurology and Sleep Medicine

Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

                       Last                                      First                                MI

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Male \_\_\_\_  Female \_\_\_\_    Birth date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_  Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*include area codes*)

Marital Status:  Single \_\_\_\_\_\_\_\_\_\_  Married/Partner \_\_\_\_\_\_\_\_\_\_  Widowed \_\_\_\_\_\_\_\_\_\_

Patient's Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Parent/Partner name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance **Subscriber** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For your convenience, we will file claims with your insurance company for you.

**ASSIGNMENT AND RELEASE OF INFORMATION**

I hereby assign my insurance benefits to be paid directly to Charlottesvillle Neurology and

Sleep Medicine and W. Christopher Winter, MD realizing that I am responsible for any non-

covered services.  I also authorize this office to release any pertinent information to my

insurance carrier.  Should this account become delinquest, the undersigned agrees to pay

all collection costs including attorney's fees.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize W. C. Winter to release medical information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_