

Appointment Date: \_\_\_\_\_ ING Doctor/Provider: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(LAST) (FIRST) (INITIAL)

Home Address: \_\_\_\_\_  
(STREET / RR BOX #) (CITY / STATE) (ZIP)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Please Circle One:    Single    Married    Divorced    Separated    Widowed    Male/Female

Name of Spouse: \_\_\_\_\_ Spouse's Birthdate: \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

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**If patient is a child: (Responsible Party Information)**

Name of Responsible Party: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Responsible Party's Relationship to Patient: \_\_\_\_\_

Responsible Party's Address: \_\_\_\_\_  
(STREET / RR BOX #) (CITY / STATE) (ZIP)

Responsible Party's Home Phone: \_\_\_\_\_ Responsible Party's Work Phone: \_\_\_\_\_

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**Please indicate below patient's nearest relative or friend not living with the patient.**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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**Referring Physician Information:**

Name of Referring Physician: \_\_\_\_\_ MD    DO    OD    DC

Referring Physician Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Family Physician Information:**

Name of Family Physician: \_\_\_\_\_ MD    DO    OD    DC

Family Physician's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information: (This section needs to be completed in order to bill insurance)**

PRIMARY INSURANCE

(Please Circle)

Company Name: \_\_\_\_\_ Co-Pay Amount: \$ \_\_\_\_\_ PPO or HMO

Policy Holder Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

SECONDARY INSURANCE

(Please Circle)

Name: \_\_\_\_\_ PPO or HMO

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

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**Accident/Injury Information:**

Injured in a non-work accident? \_\_\_\_\_ Type of accident: Auto \_\_\_\_\_ Other \_\_\_\_\_ Date of accident: \_\_\_\_\_

Is a lawsuit involved or contemplated? YES / NO

If yes, name of attorney and phone: \_\_\_\_\_

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**Worker's Compensation Information:**

Is this a worker's comp. injury? YES / NO Date of Injury: \_\_\_\_\_

Employer's Worker's Comp. Carrier Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Claim# \_\_\_\_\_

Case Manager Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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I hereby authorize the physicians and/or employees of Indianapolis Neurosurgical Group, Inc. to release any current reports or information acquired in the course of my examination or treatment by them to my family physician and referring physician(s). This authorization will remain in force for sixty (60) days from the date signed unless revoked in writing, (IN Code 16-4-8) (1-11)

I authorize and request insurance companies to pay directly to the Indianapolis Neurosurgical Group, Inc., the surgical and/or medical benefits, if any, otherwise payable to me for their services, but not to exceed the charges for those services.

Attorney fees and court costs incurred by Indianapolis Neurosurgical Group, Inc. in the collection of your account balance will be your responsibility.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

(BY PATIENT / PARENT / LEGAL GUARDIAN)\*

**\*NOTE: This authorization MUST be signed and dated by the patient unless a minor or has legal guardian; then parent or legal guardian must sign and date.**