Diagnostic Neurology
Clinic of Houston

FRONT OFFICE: 713.467.8491

PATIENT INFORMATION

Date: _____ Patient Name: _____

____ Male ____ Female Birth Date: _____ Home Phone: _____

Cell Phone: _____ EMail: _____

Address: _____ City: _____ State: ____ Zip: _____

___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated SS#: _____

Who may we thank for referring you? If by a physician, please write "MD" or "Dr.": _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

Relation to Patient: _____

Race (please select): Preferred Language: _____

___ White ___ Hispanic ___ American Indian or Alaskan Native ___ Black or African American

___ Chinese ___ Filipino ___ Japanese ___ Korean ___ Native Hawaiian ___ Pacific Islander

___ Vietnamese ___ Other ___ DECLINE TO ANSWER

PRIMARY MEDICAL INSURANCE

Name of Insured: _____ Relation to Patient: _____

Birth date of Insured: _____ SS# of Insured: _____

Name of Employer: _____ Work Phone: _____

Insurance Company: _____ ID#: _____ Group#: _____

Ins Company Address: _____ City: _____ State: ____ Zip: _____

SECONDARY MEDICAL INSURANCE

Name of Insured: _____ Relation to Patient: _____

Birth date of Insured: _____ SS# of Insured: _____

Name of Employer: _____ Work Phone: _____

Insurance Company: _____ ID#: _____ Group#: _____

Ins Company Address: _____ City: _____ State: ____ Zip: _____

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH CARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTRATING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.

_____ _____

Signature of Patient or Parent/Guardian Date