HOWARD LANTNER, M.D.
TAMEKA BROOKS, A.P.R.N

Date _____

I am seeing (check one) ❒ Dr. Stephan Lange ❒ Dr. Stephen Calderon ❒ Dr. Howard Lantner ❒ Dr. Bruce Chozick

Name _____ Age_____ Date of Birth _____

❒ Male ❒ Female Race _____ Marital Status _____ Social Security No._____

Address _____ City, State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell/Pager # _____

Employer _____ Occupation _____

Parent/Spouse _____ SSN# _____ Phone # _____

Parent/Spouse Employer _____ Phone # _____

Name and phone # of a friend or relative not living with you _____

Family Doctor's Name _____ Address _____

Referring Doctor's Name _____ Address _____

Smoker/Non smoker

INSURANCE INFORMATION **(PLEASE FILL OUT COMPLETELY)** **GIVE RECEPTIONIST INSURANCE CARDS FOR COPYING**

Were you injured on the job? ❒ Yes ❒ No Auto Accident? ❒ Yes ❒ No Date of Injury _____

Work Comp/Auto Insurance _____ Claim # _____

Address _____ City, State _____ Zip _____

Contact _____ Phone # _____

Employer (where injury occurred)_____

Primary Health Insurance _____ ID # _____ Group # _____

Address _____ City, State _____ Zip _____

Insured's Name _____ DOB _____ Employer _____

_____

Secondary Health Insurance _____ ID # _____ Group # _____

Address _____ City, State _____ Zip _____

Insured's Name _____ DOB _____ Employer _____

_____

Third Health Insurance _____ ID # _____ Group # _____

Address _____ City, State _____ Zip _____

Insured's Name _____ DOB _____ Employer _____

_____

AUTHORIZATION AND AGREEMENT

I VERIFY THAT THE INFORMATION LISTED ABOVE IS COMPLETE AND ACCURATE TO DATE. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY AND ALL CHARGES RESULTING FROM FAILURE TO DISCLOSE ACCURATE, COMPLETE AND CURRENT INSURANCE COVERAGE INFORMATION. THE UNDERSIGNED GUARANTEES PAYMENT IN FULL. GUARANTOR UNDERSTANDS ALL PATIENTS ARE PERSONALLY RESPONSIBLE FOR BALANCE AFTER THE INSURANCE COMPANY HAS MADE PAYMENT. I HEREBY ASSIGN AND DIRECT PAYMENT OF MEDICAL BENEFITS TO NEUROSURGICAL ASSOCIATES, P.C. IN THE EVENT OF COLLECTION PROCEEDINGS DUE TO LACK OF PAYMENT ON MY PART, I AGREE TO PAY ANY AND ALL COLLECTION FEES THAT MAY BE ADDED TO MY ACCOUNT IN ORDER TO RECOVER MONIES DUE

SIGNATURE _____ DATE _____

I HEREBY AUTHORIZE NEUROSURGICAL ASSOCIATES, P.C. TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S), ATTORNEY(S), PHYSICIAN(S), PHYSICAL THERAPIST(S), REHAB CONSULTANT(S) CONCERNING MY DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE MY INSURANCE CARRIER(S), ATTORNEY(S), PHYSICIAN(S), PHYSICAL THERAPIST(S) AND/OR REHAB CONSULTANT(S) TO RELEASE ANY INFORMATION NEEDED

SIGNATURE _____ DATE _____