



Neurosurgical
ASSOCIATES

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ACCT # _____

PATIENT INFORMATION

PATIENT NAME _____ ADDRESS _____

CITY, STATE, ZIP _____ MOBILE # _____

PHONE # _____ SEX _____ DOB _____ SS # _____

MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____ OCCUPATION _____

CURRENT EMPLOYER _____ PHONE # _____

MINOR PATIENT (PARENT/GUARDIAN) _____ PHONE # _____

EMERGENCY CONTACT _____ PHONE # HOME _____ WORK _____

NAME OF SPOUSE _____ EMPLOYER _____ PHONE # _____

PATIENT WAS REFERRED BY _____ PHONE # _____

REASON FOR SEEKING TREATMENT _____

IS YOUR CONDITION WORK RELATED? _____ YES _____ NO

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

ADDRESS _____ ADDRESS _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

CLAIM PHONE # _____ CLAIM PHONE # _____

PRECERT PHONE # _____ PRECERT PHONE # _____

MEMBER NAME _____ MEMBER NAME _____

MEMBER # _____ MEMBER # _____

GROUP POLICY # _____ GROUP POLICY # _____

GROUP NAME _____ GROUP NAME _____

MEMBER RELATION TO PATIENT _____ MEMBER RELATION TO PATIENT _____

MEMBERS DOB _____ MEMBERS DOB _____

PLEASE BRING IN YOUR INSURANCE CARD(S) AT THE TIME OF YOUR VISIT. PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU. PATIENT IS LIABLE FOR ALL CHARGES INCURRED FOR PURPOSES OF COLLECTION IN THE EVENT OF DEFAULT.

I give **Masaki Oishi, M.D.** permission to examine/treat my condition. If any insurance claim or Workers Compensation claim is filed, I agree that clinical and all other necessary information concerning my condition/treatment may be released to my insurance company, employer, Workers Compensation Carrier, or other treating doctor. I authorize payment to the above named physician and others that may assist him. I understand that if at any time my injury is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be rendered. I also understand that if my Workers Compensation coverage is denied for any reason, or my employer fails to honor their agreement to pay my medical bills, I will be held responsible for my total bills.

Signature of Patient/Guardian

Date

Attorney Representing You (If Applicable)