Neurology Consultants of Kansas
2135 N. Collective Lane
Wichita, KS 67206-3560
(316) 261 - 3220

☐ New Patient
☐ Update only

PATIENT INFORMATION
(Fill out both sides completely)

Today's date _____/_____/_____

PATIENT INFORMATION

Legal Name: _____ SSN: _____/_____/_____ DOB: _____/_____/_____
(LAST) (FIRST) (MIDDLE)

☐ Male ☐ Female Address: _____ Apt: _____ City: _____ State:_____ Zip:_____

Marital Status:_____ Student ☐ Full time ☐ Part time Home Phone: (____)_____

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (specify) _____

Race: ☐ White ☐ Black or African-American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Declined

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Work Phone: (_____)_____Ext:_____ Cell Phone: (_____)_____

Fax: (_____)_____ Email: _____

Employer: _____ Employment Status ☐ FT ☐ PT ☐ Not Employed

☐ Same as Patient

EMERGENCY CONTACT INFORMATION

Legal Name: _____ Address: _____ Apt: ____

City: _____ State: _____ Zip: _____ Work Phone: (____)_____ Ext:_____

Home Phone: (____)_____ Relation to Patient: _____

Legal Guardian? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION (For Billing) ☐ Same as Patient ☐ Same as Insured

Legal Name: _____ SSN: _____/_____/_____ DOB: _____/_____/_____
(LAST) (FIRST) (MIDDLE)

☐ Male ☐ Female Address: _____ Apt: _____ City: _____ State:_____ Zip:_____

Home Phone: (____)_____ Work Phone: (____)_____Ext:_____

Relation to Patient: _____

Employer: _____ Employment Status ☐ FT ☐ PT ☐ Not Employed

Referring Physician's Name: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP

Primary Care Physician's Name: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP

Pharmacy Name: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP

PRIMARY INSURANCE

Policy Number: _____ Group Number: _____ Effective Date: _____/_____/_____

Insurance Company: _____ Address: _____

Primary Doctor: _____ Patient's Relation to Insured: _____

Policy Holder's Name: _____ DOB: _____/_____/_____ ☐ Male ☐ Female
(LAST) (FIRST) (MIDDLE)

Address: _____ Apt: _____ City: _____ State:_____ Zip:_____

Work Phone: (____)_____Ext:_____ Home Phone: (____)_____

Employer: _____ Employment Status ☐ FT ☐ PT ☐ Not Employed

SECONDARY INSURANCE

Policy Number: _____ Group Number: _____ Effective Date: _____/_____/_____

Insurance Company: _____ Address: _____

Primary Doctor: _____ Patient's Relation to Insured: _____

Policy Holder's Name: _____ DOB: _____/_____/_____ ☐ Male ☐ Female
(LAST) (FIRST) (MIDDLE)

Address: _____ Apt: _____ City: _____ State:_____ Zip:_____

Work Phone: (____)_____Ext:_____ Home Phone: (____)_____

Employer: _____ Employment Status ☐ FT ☐ PT ☐ Not Employed

OTHER FAMILY MEMBERS ON ACCOUNT ☐ No Other Family Members

Legal Name: _____ DOB: _____/_____/_____
(LAST) (FIRST) (MIDDLE)

Legal Name: _____ DOB: _____/_____/_____
(LAST) (FIRST) (MIDDLE)

Legal Name: _____ DOB: _____/_____/_____
(LAST) (FIRST) (MIDDLE)

Legal Name: _____ DOB: _____/_____/_____
(LAST) (FIRST) (MIDDLE)

I understand my signature requests that payment be made to the provider and authorizes release of medical information necessary to pay the claim. A photocopy of the authorization and assignment shall be considered as valid as the original. If Item 12 of HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown above. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination for the Medicare/Other Insurance company. Co-pay must be paid at the time of service. Please let us know if you need more information.

Patient's Signature: _____ Date: _____/_____/_____

Parent/Guardian Signature: _____ Date: _____/_____/_____
(if patient is a minor)