

Overlake Neurology
Dr. Daniel Fosmire & Dr. D. Gregory Gorman
1135 116th Ave. NE Suite 200 Bellevue, WA 98004

PATIENT INFORMATION

Full Name _____		
Last	First	MI
Social Security # _____	Birthdate: _____	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Home Address _____		
City, State, Zip _____		
Home Phone _____	Work Phone _____	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Other _____		

INSURANCE INFORMATION Please provide the receptionist with your card(s)

Primary Insurance Company		
Insurance Name _____	Subscriber's Relationship to Patient _____	
Subscriber Name _____	Date of Birth _____	SSN _____
Policy Id # _____	Group # _____	Copay _____
Secondary Insurance Company		
Insurance Name _____	Subscriber's Relationship to Patient _____	
Subscriber Name _____	Date of Birth _____	SSN _____
Policy Id # _____	Group # _____	Copay _____

RESPONSIBLE PARTY Required if patient in under the age of 18 or not responsible for their own bill

Full Name _____	Relationship to patient _____
Mailing Address _____	City, State, Zip _____

EMERGENCY CONTACT

Name _____	Relationship to patient _____
Day/Work Phone () _____	Home/Eve Phone () _____

As a patient you have certain responsibilities in your care. Those responsibilities include:

- * Providing current, accurate billing information at all visits.
- * Provide the physician with complete medical history.
- * Being aware of which benefits you insurance does and does not cover, including the need for referrals.
- * Failure to cancel appointments 24 hours in advance will result in a fee.

I hereby authorize my insurance benefits to be paid directly to Overlake Neurology, Inc., P.S. and I am financially responsible for any balance due. I authorize Overlake Neurology, Inc., P.S. to release any information necessary to process any insurance claim.

My signature acknowledges understanding and consent to all of the above information.

Signature _____ Date _____