Last Name: _____ ***First Name:*** _____ ***MI*** ____ ***Date of Birth:*** _____

Social Security: _____ ***Marital Status:*** _ *Married* _ *Divorced* _ *Single* _ *Widowed* _ *Unknown*

Sex: _ *Male* _ *Female* ***Home Phone:*** _____ ***Cell Phone:*** _____

Best Number for Reminders: __ ***Home*** __ ***Cell*** __ ***Other (Specify):*** _____

Address:

_____

Email Address: _____ ***Language:*** _____

Race: __ *American Indian or Alaska Native* __ *Asian* __ *Black or African American*
__ *White* __ *Native Hawaiian or Other Pacific Islander* __ *Hispanic* __ *Refused*

Ethnicity: __ *Hispanic* __ *Not Hispanic or Latino* __ *Refused*

Pharmacy Name and Number _____ ***Referring Physician:*** _____

Emergency Contact Information:

Name: _____ ***Relationship:*** _____ ***Phone #:*** _____

Address: _____

Do you have an advance directive plan? __ Yes __ No.

If yes, is it a __ living will __ power of attorney __ Organ donor __ Other, Specify _____

Primary Insurance: _____ ***ID Number:*** _____ ***Group #:*** _____

Name of insured: _____ ***DOB:*** _____ ***Relationship:*** _____

Signature: _____ Date: _____

Secondary Insurance: _____ ***ID Number:*** _____ ***Group #:*** _____

Name of insured: _____ ***DOB:*** _____ ***Relationship:*** _____

I certify that the above information is correct to the best of my knowledge and authorize Neurocare Plus to submit claims to the above insurance companies, and authorize Neurocare Plus to act as an agent on my behalf to appeal any claim denial. I understand that I am responsible for all charges whether or not covered by my insurance. I also understand that a no show fee will be applied for all missed appointments not cancelled or rescheduled 24 hrs prior to the scheduled time, and that this charge is not covered by insurance. By signing this form, I voluntarily give consent to such medical care, treatment and diagnostic tests that Dr. Nammour and his designated associates or assistants believe are necessary.

Signature: _____ Date: _____