Athens Concussion & Neuropsychology Center Patient Demographics

Patient ID:	**Pharmacy:**
Today's Date:	Location/Phone:
Patient Information:	
Name: (Last, First, MI)	
Date of Birth: (MM/DD/YY)	Social Security #:
Phone #: ( )	Secondary Phone #: ( )
Address:	
City, State, Zip:	
Referring Doctor:	Emergency Contact:
Referring #:	Emergency #:
Referring Address:	Relationship:
Primary Insurance:	
Primary Insurance Name:	
Policy Number:	
Group Number:	
Claims Address:	
Primary Policy Holder:	
Policy Holder DOB:	
Secondary Insurance:	
Secondary Insurance Name:	
Policy Number:	
Group Number:	
Claims Address:	
Primary Policy Holder:	
Policy Holder DOB:	
Financially Responsible Party/Guarantor:	
Guarantor Name:	
Date of Birth (MM/DD/YY):	Social Security #:
Address:	Phone #: ( )
City, State, Zip:	Relationship to Patient:

I hereby certify that all of the information provided above is correct to the best of my knowledge. I authorize Athens Concussion & Neuropsychology Center, LLC and its affiliates to receive insurance payments for services provided. I consent to allow Athens Concussion & Neuropsychology Center, LLC and its affiliates to release any medical information necessary to process claims as well as to my referring and primary care physicians. I consent to allow fax transmissions of my medical records. I understand and acknowledge that I am financially responsible for any and all copays, deductibles, co-insurance, or non-covered services. I understand that all payments for charges incurred are due at time of service, unless previous financial arrangements have been made prior to my appointment.

Patient/Guarantor Signature:	**Date:**