GOLDEN TRIANGLE NEUROCARE, LLP
PATIENT INFORMATION

KUBALA ANGEL LO SILVA YU

NAME:_____
LAST FIRST MIDDLE INTIAL

ADDRESS:_____
STREET OR PO BOX CITY, STATE ZIP

DATE OF BIRTH:_____ GENDER M/F MARITAL STATUS S / M / SEPARATED/ D/ W

PHONE: _ _ _-_ _ _-_ _ _ _ SS# _ _ _-_ _ -_ _ _ _ DL # _____ STATE_____

SPOUSE NAME_____ NEAREST RELATIVE_____
PHONE RELATIONSHIP

PATIENT EMPLOYER_____
COMPANY ADDRESS CITY/ST/ZIP PHONE

WORK PHONE: _ _ _-_ _ _-_ _ _ _ CELL PHONE/ PAGER: _ _ _-_ _ _-_ _ _ _

PRIMARY INSURANCE INFORMATION

POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

POLICY HOLDER DATE OF BIRTH:_____ SS# OF POLICY HOLDER:_____

POLICY HOLDER EMPLOYER & ADDRESS:_____EMPLOYER #:_____

INSURANCE COMPANY_____

INSURANCE COMPANY ADDRESS:_____

POLICY#:_____ GROUP: _____

SECONDARY INSURANCE INFORMATION

POLICY HOLDER:_____ RELATIONSHIP TO PATIENT:_____

POLICY HOLDER DATE OF BIRTH:_____ SS# OF POLICY HOLDER:_____

POLICY HOLDER EMPLOYER:_____ EMPLOYER PHONE:_____

INSURANCE COMPANY_____

INSURANCE COMPANY ADDRESS:_____

POLICY#:_____ GROUP: _____

AUTHORIZATION TO TREAT AND RELEASE INFORMATION

I hereby authorize GOLDEN TRIANGLE NEUROCARE, LLP to receive and release any medical or surgical information necessary for the treatment of my medical or surgical conditions and in order to process any and all insurance claims on my behalf. I also assign all medical and or/surgical benefits including major medical to which I am entitled to GOLDEN TRIANGLE NEUROCARE, LLP (DRS. KUBALA, ANGEL, LO, SILVA AND YU AND ANDY VAUGHAN, PA). I accept responsibility for any unpaid portions of these claims that my health plans do not cover and will make all payments to GOLDEN TRIANGLE NEUROCARE, LLP in a timely and conscientious manner. I further that it is the policy of GTN to NOT dispense narcotic pain medications and that doing so would be a rare exception at the physicians descretion. This acknowledgement will remain in effect until revoked by me in writing. A photocopy of this acknowledgement accompanied with my signature is to be considered valid as original.

_____

Patient Signature or/ Parent Signature if under 17Years of age DATE