MIDWEST NEUROSURGERY ASSOCIATES, P.A. *Date*____________

Andrew B Kaufman, M.D. Geoffrey L. Blatt, M.D. Jonathan D. Chilton, M.D.
Frank Feigenbaum, M.D. William S. Rosenberg, M.D.

PATIENT INFORMATION

Name (last)	(first)	(middle)	Social Security #

Date of Birth	Age	Gender	Marital Status

Address	City, State, Zip	Home Phone	Cell Phone

Employer	Employer's Address	City, State, Zip	Work Phone

Spouse/Parent/Significant Other	Contact Phone #

Referring Physician	City, State	Phone	Primary Care Physician	Phone

EMERGENCY CONTACT

Name	Relationship to Patient	Contact Phone #

Address	City, State, Zip

INSURANCE INFORMATION

Primary Insurance Company	Policy Holder/Relationship	Policy #	Group #/Name

Secondary Insurance Company	Policy Holder/Relationship	Policy #	Group #/Name

DO YOU HAVE REGULAR MEDICARE? Yes____ No____ **DO YOU HAVE A REPLACEMENT HMO**? Yes____ No____

IS THIS A WORK RELATED INJURY? Yes ____ No ____

IS THIS DUE TO AN AUTO ACCIDENT? Yes ____ No ____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits directly to MIDWEST NEUROSURGERY ASSOCIATES, P.A. I consent to the release of medical information to my insurance company and to my referring physician.

____
Signature Date

MEDICARE LIFETIME CERTIFICATE

I request that payment of authorized Medicare benefits be made on my behalf to MIDWEST NEUROSURGERY ASSOCIATES, P.A. for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________________ ______________________________
Signature of Beneficiary Patient Medicare # Date

MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to MIDWEST NEUROSURGERY ASSOCIATES, P.A. for all claims on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Beneficiary signature ______________________________ Date ______________________

MEDIGAP Insurance Company ______________________________ Policy # ______________________