**TODAY'S DATE:** _____

## -Patient Information-

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Birth date: _____ Gender (circle): M F L G B T Q A I

To receive messages related to appointment reminders, medical information via telephone, SMS text messaging, and/or email, please check the boxes next to the contact information:

☐ Home #_____ ☐ Daytime #_____ ☐ Cell # _____

☐ Email: _____

*By providing your informed consent where indicated, you agree to participate in our text (SMS) messaging service.

Patient Employed by: _____ Occupation: _____

Whom may we thank for referring you? _____

Primary Care Physician: _____

## -Primary Insurance-

Name of Primary Insurance: _____ Policy Holder: _____

Relationship to Patient: _____ Policy Holder DOB: _____

## -Secondary Insurance- ☐ Yes ☐ No -

Name of Secondary Insurance: _____ Policy Holder: _____

Relationship to Patient: _____ Policy Holder DOB: _____

## -Pharmacy Information-

Pharmacy Name: _____ Phone: _____ Fax: _____

Address: _____

In case of emergency, who should be notified? _____ Phone: _____

## -Assignment, Release and Financial Responsibility-

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to David M Katz, MD/ Bethesda Neurology, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, including reasonable attorney's fees and costs of collection in the event of default. I hereby authorize Dr. Katz to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date