FEIGENBAUM NEUROSURGERY

Frank Feigenbaum, M.D., FAANS, FACS

Date_____

PATIENT INFORMATION

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

Date of Birth Age Gender Marital Status

Address City, State Zip Home Phone Cell Phone

Employer Employers Address (city, state, zip) Work Phone

E-Mail Address 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

Name Relationship to Patient Contact Phone Address, City, State, Zip

INSURANCE INFORMATION

Primary Insurance Company Policyholder/Relationship/Date of Birth Policy # Group #/Name

Secondary Insurance Company Policyholder/Relationship/Date of Birth 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_____ (*If yes, please complete workers compensation form in addition*)

IS THIS DUE TO AN AUTO ACCIDENT? Yes_____ No _____(*If yes, please complete auto information form in addition*)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize payment of medical benefits directly to FEIGENBAUM NEUROSURGERY, 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 FEIGENBAUM NEUROSURGERY, 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 FEIGENBAUM NEUROSURGERY, 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 # _____

Revised February 2018

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