COMPREHENSIVE
NEUROLOGY SPECIALISTS

Dr Ishaq Ali MD

Comprehensive Neurology Specialists, PLLC

Date:_____

Primary Care Physician(Last,First): _____

Patient Information: Referring Physician(Last, First):_____

Name:_____
LAST FIRST M.I.

Address:_____

City:_____State:_____Zip:_____

Home Phone:(_____)_____Cell Phone:(_____)_____

E-mail: _____

Date Of Birth:_____/_____/_____Age:_____Sex: M / F Social Sec. #:_____-_____-_____

Marital Status:_____ Primary Language: English/Spanish/Other:_____

Race: White/Black/Hispanic/Other_____ Ethnicity: Hispanic/Latino? Yes/No

Employer:_____Phone:(___)_____

Emergency Contact:_____Relation:_____Phone:(___)_____

Address:_____City:_____State:____Zip:_____

Responsible Party (If Patient Is a Minor, Name Of Guardian):_____

Insurance Information:

•Primary **Date of Birth:** _____/_____/ _____(if other than patient)

Name Of Insurance Co.:_____Phone:(___)_____

Address:_____City:_____State:____Zip:_____

Name Of Insured Person:_____Social Sec. #:_____-_____-_____

Insurance I.D. #:_____Group # Or Name:_____

•Secondary **Date of Birth:** _____/_____/ _____(if other than patient)

Name Of Insurance Co.:_____Phone:(_____)_____

3017 E.Renner Road, Suite 100, Richardson, TX 75082 Phone# 469-902-9878 Fax#469-638-8399

www.comprehensiveneurologyspecialists.com scheduling@comprehensiveneurologyspecialists.com

Address:_____City:_____State:____Zip:_____
Name Of Insured Person:_____Social Sec. #:_____-_____-_____
Insurance I.D. #:_____Group # Or Name:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign Comprehensive Neurology Specialists, PLLC my medical reimbursement benefits under my insurance policies listed above. I understand that services not covered by my insurance are my financial responsibility and are due at time of service unless other arrangements have been made.

HIPAA Notice of Privacy Practices:

I understand that Comprehensive Neurology Specialists, PLLC has established a Notice of Privacy Practices that provides information about how my protected health information can be used and disclosed. I consent to the use of my protected health information for the treatment, payment, and health care options. I acknowledge that I have received a copy of the Notice of Privacy Practice to read and obtain a copy to keep by requesting one from the front office.

Patient's Signature:_____Date:_____

3017 E.Renner Road, Suite 100, Richardson, TX 75082 **Phone# 469-902-9878** **Fax#469-638-8399**

www.comprehensiveneurologyspecialists.com **scheduling@comprehensiveneurologyspecialists.com**