High Country Neurology
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Phone 828-262-0600 Fax 828-262-0807
www.highcountryneurology.com info@highcountryneurology.com

NEW PATIENT INFORMATION

Name: (First)______________________ **(MI)** ____ **(Last)** ______________________________
Date of Birth: ______________________ **Social Security #:** __________________________
Mailing address: (Street or PO Box) ____
(City) ____________________________ **(State)** _________ **(Zip)** ____________
Home Phone: ____________ **Work Phone:** _______________ **Cell Phone:** _______________
(please circle the phone number you would prefer to be used for appointment reminders)
E-Mail: ____ (please check here ____ if you would like us to set up internet/online access for you to view your medical records from this office)
Employer: ____
Sex: Male Female **Marital status:** Single Separated Married Divorced Widowed
Race: ________________ **Ethnicity:** _____________ **Primary Language:** __________
Referring doctor: ________________________ **Primary/General doctor:** _________________
Preferred pharmacy: (name) _____________________**(city)** _______________ **(state)** ______
Winter address (if applicable): (Street or PO Box) ____________________________________
(City) ____________________________ **(State)** ________________ **(Zip)** _________________
Winter Phone: ________________

RESPONSIBLE PARTY/EMERGENCY/INSURANCE CARD INFORMATION

Person Responsible for account/name on insurance card:
(if not the patient) ____
Date of Birth: ______________________ **Social Security #:** __________________________
Relationship: ____
Address: (Street or PO Box) ____
(City) __________________________ **(State)** ______________ **(Zip)** _____________
Home Phone: ________________ **Work Phone:** ______________ **Cell Phone:** ____________
Emergency Contact: ____
Relationship: ____
Home Phone: ________________ **Work Phone:** _____________ **Cell Phone:** _____________
Power of Attorney/Guardian (if applicable): ____
Home Phone: _________________ **Work Phone:** _____________ **Cell Phone:** ____________

ACCIDENT/WORKMAN'S COMPENSATION INFORMATION

(please skip this section if not applicable to your case)
Date of accident: _____________________ **Due to ( ) Auto accident ( ) Work injury ( ) other**
Do you have an attorney? (Name)___________________________ **Phone:** ________________
If workman's comp; (Employers Name/Address)
____
WC Insurance company: ________________________ **Case Manager:** _________________
Claim #: ____________________________ **Insurer Phone:** ______________________________