High Country Neurology
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Phone 828-262-0600 Fax 828-262-0807
www.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: _____ E-Mail: _____
Employer: _____
Sex: Male Female **Marital status:** Single Separated Married Divorced Widowed
Race: _____ Ethnicity: _____ Primary Language: _____

Referring provider: _____
Primary/General provider: _____
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: _____ Email: _____

Emergency Contact: _____
Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____

Power of Attorney/Guardian (if applicable): _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____