**Dr Supriya Thirunarayanan MD**

**Comprehensive Neurology Center, PA**

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:(______)____________________

Address:_______________________________City:___________________State:_____Zip:_______________

Name Of Insured Person:___________________________Social Sec. #:_________-_________-_________

Insurance I.D. #:______________________________Group # Or Name:______________________________



1600 Coit Road, Suite 406, Plano, TX 75075 Phone# 469-977-1010 Fax#469-977-1155

www.compneurocenter.com scheduling@compneurocenter.com

# AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign Comprehensive Neurology Center, PA 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 Center, PA 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:______________________________

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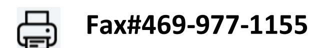
Phone# 469-977-1010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