NEUROLOGY & SLEEP SPECIALISTS
an affiliate of Mountain View Hospital

INTAKE

Name_____**Email**_____
First Middle Last

Address_____
Street City State Zip

Date of Birth_____ **Age** ____ **Sex** ____**Race** _____ ***Hispanic/Latino/Spanish origin?*** **Yes/No**

Social Security # ____-___-_____ Ref Phys _____ **Primary Care Phys** _____

Home/other phone_____ **Cell** _____ **Other #** _____

Occupation_____**Employer**_____

Spouse's Name_____ **DOB**_____ **Phone number**_____

INSURANCE

(A copy of your insurance cards are required to be presented on or prior to initial Date of Service)

Primary Insurance_____
Insurance Name Policy # Group #

Policy Holder_____
Name SS# Date of Birth

Secondary Insurance_____
Insurance Name Policy # Group #

Policy Holder_____
Name SS# Date of Birth

EMERGENCY CONTACTS

Emergency Contact #1 _____
Name relationship Phone #

Emergency Contact #2 _____
Name relationship Phone #

Patient signature: _____ ***Date:*** _____

**By signing, I authorize staff at the Neurology & Sleep Specialists to contact the people above in the event of an emergency.*

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PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

☐ Cell Phone _____
- OK to leave message with detailed information
- Leave message with callback number only

☐ Home Telephone _____
- OK to leave message with detailed information
- Leave message with callback number only

☐ Work Telephone _____
- OK to leave message with detailed information
- Leave message with callback number only

☐ Written Communication
- OK to mail to home address
- OK to mail to my work address
- OK to fax to this number _____

☐ OK TO RELEASE INFORMATION TO:

- Name: _____Relationship: _____ Phone #: _____
- Name: _____Relationship: _____ Phone #: _____
- Name: _____Relationship: _____ Phone #: _____

_____ _____

Patient Signature ***Date***

_____ _____

Print Name ***Date of Birth***