University of California
San Francisco
UCSF
Department of Neurology
Surgical Movement Disorders

PATIENT INFORMATION

Name_____
First Middle Initial Last

Address: _____
Street City State Zip

Age: _____ DOB: _____ Sex: ☐M ☐F SSN: XXX – XX -_____

Daytime Phone: _____ Evening Phone: _____

Employer: _____ Occupation: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Spouse's Name: _____

Referring Physician & Phone: _____

Primary Physician& Phone:_____

EMERGENCY CONTACT:

Name:_____ Relationship to patient: _____

Daytime Phone: _____ Evening Phone: _____

INSURANCE INFORMATION:

Subscriber name:_____

ID #_____

Grp # _____

Work Comp D.O.I: _____

Adjuster Name & Phone

_____

RELEASE OF INFORMATION/PAYMENT AUTHORIZATION

I authorize the release of any medical information necessary to process claims for payment. I permit a copy of this authorization to be used in place of the original. I authorize direct payment of benefits to the physician for services rendered. I realize I am responsible for payment of charges not covered by insurance. I certify that the information I have reported with regard to my insurance coverage is correct.

_____
Signature Date

_____ _____
Initials Date