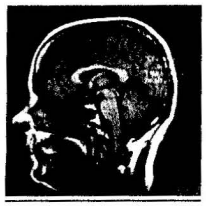

# San Jose Pacific Neurology Center
# Professional Corporation

Patient name: _____ DOB: _____
*last name* *first name* *month* *day* *year*

Address: _____
*Street* *city* *state* *zip*

Social Security #: _____-_____-_____ Marital Status: _____ Sex: M F

Home phone: ( ) _____-_____ Email address:_____

Cell phone: ( ) _____-_____ Receive text for appointment confirmation? Yes No

Referred by: _____ Primary care physician: _____

Race: _____ Ethnicity (Please circle): Hispanic Non-Hispanic

Preferred language: _____ Translator needed (Please circle): Yes No

---

## EMERGENCY CONTACT

Name: _____ Relationship: _____

Primary phone: ( ) _____-_____

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## INSURANCE INFORMATION

Insurance Carrier: _____ self spouse parent

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## AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I, the undersigned, agree on the following: (**please initial in the spaces**)

- It is my responsibility to verify the insurance coverage of laboratory or x-ray facilities before accepting their services. ( )
- There is a $25.00 to $50.00 charge for any missed appointments or cancellations within 24 hours. This fee is not be covered by Medicare, Medi-Cal, or insurance policies. ( )
- I hereby authorize Dr. Gupta and Dr. Shah permission to administer the necessary medical treatment and permission to release any information to insurance carriers concerning my illness. I hereby assign my insurance benefits to be paid directly to Dr. Gupta and Dr. Shah. I am financially responsible for non-covered services. I agree that delinquent balances beyond 30 days are subject to interest and collection fees. ( )

_____ _____
*SIGNATURE* *DATE*

SAN JOSE PACIFIC NEUROLOGY CENTER
200 JOSE FIGUERES AVENUE SUITE 200 SAN JOSE CA 95116
P 408-347-1600 F 408-347-0600