

San Jose Pacific Neurology Center Professional Corporation

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Address: Street city state zip	Patient name:	DOB:									
Street city state zip Social Security #: Marital Status: Sex: M F Home phone: () Email address:		first name	month	day	year						
Social Security #:											
Home phone: () Email address:											
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Referred by: Primary care physician: Ethnicity (Please circle): Hispanic Non-Hispanic Preferred language: Translator needed (Please circle): Yes No EMERGENCY CONTACT Name: Relationship: Relationship: INSURANCE INFORMATION Insurance Carrier: self spouse parent AUTHORIZATION TO PAY BENEFITS TO PROVIDER 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. () Gupta and Dr. Shah, I am financially responsible for non-covered services. ()	-										
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