

MICHAEL G. KAISER, M.D.
NEUROSURGICAL ASSOCIATES, P.C.
710 WEST 168TH STREET
NEW YORK, NY 10032

ACCT # _____ UNIT # _____

Last Name _____ **First Name** _____

Date of Birth _____ Sex _____ Home# _____ Cell# _____

Social Security# _____ Address _____

CITY _____ ST _____ ZIP _____

Employer's Name _____ Work # _____

ADDRESS _____ FAX # _____

CITY _____ ST _____ ZIP _____

Spouse last Name _____ **First Name** _____

Date of Birth _____ Social Security _____ Work # _____

FATHER'S FIRST NAME _____ **MOTHERS FIRST NAME** _____

REFERRING M.D. _____ PH# _____

ADDRESS _____

GUARANTOR NAME (If different from above) _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____ SS# _____ DOB _____

CITY _____ ST _____ ZIP _____ SEX _____

HOME# _____ WK# _____

FAX # _____ CELL# _____

PRIMARY INSURANCE _____ PH # _____

ADDRESS _____

POLICY # _____ GROUP # _____

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SECONDARY INSURANCE _____ PH # _____

ADDRESS _____

POLICY # _____ GROUP # _____

_____ WORKER'S COMP / _____ NO FAULT

CARRIER _____

DATE OF ACCIDENT _____ CASE # _____

POLICY # _____ REP. NAME _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

PHONE# _____ FAX# _____

ASSIGNMENT OF BENEFITS: I hereby authorize assignment of payment directly to MICHAEL G. KAISER, M.D. My current policy prohibits direct payment to the Doctor. I will forward the check to him at the above address. I understand that I am financially responsible for charges that are not covered by my insurance.

SIGNATURE _____ DATE _____

I am aware that Michael G. Kaiser, M.D. does not participate with my Commercial Insurance.

SIGNATURE _____ DATE _____