Lansing Neurosurgery
A DIVISION OF COMPASS HEALTH

1575 RAMBLEWOOD DRIVE
EAST LANSING, MI 48823
517 827-1800 (P)
517 827-1805 (F)

DEMOGRAPHIC FORM

Please provide the following information for our records.
Please bring your INSURANCE CARD and DRIVERS LICENSE to your appointment. Thank you.

Patient Name: _____ **DOB:**_____

Sex: _____Social Security Number: _____

Marital Status:_____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ White
☐ Hawaiian or Pacific Islander ☐ Other (please list) _____

Ethnic Group: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other (please list) _____

Preferred Language: ☐ English ☐ Spanish ☐ Other (please list) _____

Address: _____

City, State, Zip Code: _____

Telephone -- Home: _____Work: _____ Cell:_____

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Email address:_____

How would you prefer to be contacted: ☐ Phone ☐ Mail ☐ Email

How would you prefer to receive reminders from our office? *(Please choose one reminder method.)*

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Mail ☐ Email

Referred By: _____ Family Physician: _____

Address: _____ Location seen:_____
Telephone: _____ Telephone: _____

Spouse/Partner Name: _____ Spouse/Partner Employer: _____

Name of Parents (if patient is dependent/minor): _____

Address (if different from patient): _____

City, State, Zip Code: _____

Emergency Contact Not Living With You: _____

Relationship to Patient: _____ Telephone: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Employer: _____ Occupation: _____

Address: _____

City, State, Zip Code: _____

Is This Visit Related to Any of the Following?

Work Injury	☐ Yes	☐ No
Auto Accident	☐ Yes	☐ No
Other Incident	☐ Yes	☐ No

Please Explain: _____

If you answered yes to any of the above, please list the date of injury: _____

☐ My problem did not result from an accident.

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Physician Consent for Medical Treatment

I hereby authorize and direct Dr. _____to treat:

_____ Date of Birth:___/___/____
(Patient's full name)

I, the undersigned, agree to the following:

I hereby voluntarily consent for care encompassing diagnostic procedures and treatment by my physician, his assistant, designees or consultants, as may be necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN:

_____(if required)
Parent/Legal Guardian must remain present during entire appointment.

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INSURANCE INFORMATION

INSURANCE COMPANY: _____ Primary Insurance: ☐ Yes ☐ No

Address: _____

City, State, Zip Code: _____

Policy/Claim Numbers: _____

Subscriber: _____ Date of Birth: _____ Relationship to Patient: _____

Employer of Subscriber (if different from above): _____

Address of Employer (if different from above): _____

Claim Adjuster Name (if applicable): _____ Telephone: _____

OTHER INSURANCE: (Insurance Company) _____

Address: _____

City, State, Zip Code: _____

Policy/Claim Numbers: _____

Subscriber: _____ Date of Birth: _____ Relationship to Patient: _____

Employer of Subscriber (if different from above): _____

Address of Employer (if different from above): _____

Claim Adjuster Name (if applicable): _____ Telephone: _____

MEDICARE:

Medicare Number: _____ Are you or your spouse employed? ☐Yes ☐No

What is the basis for the patient's entitlement to Medicare?

☐ Age ☐ Disability ☐ Renal Disease ☐ Other (Explain) _____

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Authorizations

- I authorize the release of any medical information necessary to process my insurance claim.
- I authorize payment of medical benefits to Compass Health for services rendered when they
  request that payment be made directly to them.
- I understand that I am ultimately responsible for payment of services that are rendered to me.
- I understand that Compass Health will bill my insurance company, but that I am responsible for any balance that my insurance does not pay as well as any copayments and/or deductibles.

_____ _____
Signature (Patient, Responsible Party) Date

Consent for Use and Disclosure of Your Health Information

By initialing below, you acknowledge that you have Been Offered Received the Compass Health Notice of Privacy Practices.

I Do☐ Do not☐ authorize Compass Health to leave detailed messages on my voicemail.

_____ _____
Initial Date

Authorization for release of Protected Health Information

If you choose to have your Protected Health Information released to another person either verbally or in writing, please complete the information below. Signing the below authorization will not affect your treatment at Compass Health.

I , _____approve Compass Health to release my Health records to the individuals listed below at my request.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

I understand this authorization is valid for one year from this date and can be revoked or revised at any time with written notice.

_____ _____
Signature Date