Town & Country Neurology

Sevak Ohanian, M.D.

Thank you for selecting Dr. Ohanian at Town & Country Neurology for your current healthcare needs! We strive to provide you with the best possible healthcare. To help us meet all your needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help.

Personal Information

Date_____ Referred by _____Birthdate_____

Full Name _____ Last 4 # of SS/_____

Check Appropriate Box:
____ Male ____ Female ____ Minor ____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

Race ☐ American Indian or Alaska Native ☐ White ☐ Native Hawaiian or other Pacific Islander ☐Black or African American ☐ Asian ☐ Declined

Ethnicity ☐ Declined ☐Hispanic or Latino ☐Non Hispanic or Latino

Street Address_____ Pharmacy# _____

City _____ State/Prov _____ Zip/ PC _____

Home Phone ( )_____ - _____ Work Phone ( ) _____-_____ ext. ____ Cell Phone( )_____-_____

Email _____ Employer _____ Occupation _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Cell/Home# _____ Work# _____

Responsible Party Information (Who is responsible for the account if different from patient?)

Name_____ Relationship to patient _____

Birthdate _____ Driver License# _____ SS#/SIN _____

Street Address _____ E Mail_____

City _____ State/Prov _____Zip/PC_____

Employer _____ Occupation _____

Home Phone ( )_____-_____ Work Phone ( )_____-_____ ext_____ Cell Phone ( )_____-_____

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Insurance Information

Primary Insurance	Additional / Secondary Policy
Name of Insured _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
Insured's Birth Date _____	Insured's Birth Date _____
SS#/SIN _____	SS#/SIN _____
Employer _____	Employer _____
Insurance _____	Insurance _____
Member ID#_____	Member ID#_____
Group# _____	Group# _____
Phone# _____	Phone# _____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor and or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that failure to cancel an appointment or procedure 24 hours in advance will incur a "No Show Fee".

X_____ Date _____

Signature of patient or parent/guardian if minor

Late Charges Note: If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% will be added on the balance each month of the unpaid and owed amount (as allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at any time, please ask we are always happy to help.

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