

**Rocky Mountain Neurology**  
**Dr. Amelia Scott Barrett and Dr. Daniel J. Kitei**

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**PATIENT DEMOGRAPHICS FORM**

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FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

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LAST NAME: \_\_\_\_\_ Nickname: \_\_\_\_\_

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ADDRESS: \_\_\_\_\_

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CITY, STATE, ZIP: \_\_\_\_\_

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HOME PHONE: \_\_\_\_\_

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WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

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EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

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I WOULD LIKE TO BE CALLED AT:	home	work	other
MESSAGES CAN BE LEFT AT	home	work	other

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SOCIAL SECURITY NUMBER: \_\_\_\_\_  
(needed for insurance authorizations)

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DATE OF BIRTH: \_\_\_\_\_

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MALE OR FEMALE? \_\_\_\_\_ SINGLE OR MARRIED? \_\_\_\_\_

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NAME OF INSURED: \_\_\_\_\_ SSN: \_\_\_\_\_

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RELATIONSHIP TO INSURED: \_\_\_\_\_

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EMERGENCY CONTACT:	ADDRESS	PHONE
NAME		

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REFERRING PHYSICIAN: \_\_\_\_\_

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PCP (Primary care doctor): \_\_\_\_\_

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**PATIENT IS RESPONSIBLE FOR OBTAINING ALL REFERRALS & Ins. AUTHORIZATIONS**

- Regardless of insurance, I acknowledge that I am ultimately responsible for payment of services provided by Drs. Barrett and Kitei. I agree to pay all fees not covered and/or denied by my insurance company.
- I hereby authorize assignment of benefits to be paid directly to Drs. Barrett and Kitei.
- I authorize Drs. Barrett and Kitei to provide protected health information to my insurance company for billing purposes.
- I acknowledge review of HIPPA notice, and have received a copy if I requested it.
- I hereby authorize Rocky Mountain Neurology to add a \$10 late fee per month to all past due charges on my account

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PATIENT SIGNATURE

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DATE