Sylvia Zuniga-Barboni, M.D.

Advanced Neurology of the Palm Beaches

PATIENT INFORMATION

DATE

LAST NAME FIRST NAME MIDDLE NAME

SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W DATE OF BIRTH: ___/___/___ SOCIAL SECURITY #:

MAILING ADDRESS CITY STATE ZIP CODE

ALTERNATE ADDRESS CITY STATE ZIP CODE

HOME PHONE E-MAIL CELL PHONE

PLACE OF EMPLOYMENT WORK PHONE

WORK ADDRESS CITY STATE ZIP CODE

REFERRING DOCTOR PHONE UPIN #

ADDRESS CITY STATE ZIP CODE

PARENTAL INFORMATION

INFORMATION IS NEEDED ON THE PARENT WHO IS INSURED. IF THERE IS NO INSURANCE THEN INFORMATION IS NEEDED ON THE FINANCIALLY RESPONSIBLE PARENT.

LAST NAME FIRST NAME MIDDLE NAME

SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W DATE OF BIRTH: ___/___/___ SOCIAL SECURITY #:

PLACE OF EMPLOYMENT WORK PHONE

WORK ADDRESS CITY STATE ZIP CODE

SPOUSAL INFORMATION

LAST NAME FIRST NAME MIDDLE NAME

DATE OF BIRTH: ___/___/___ SOCIAL SECURITY #:

PLACE OF EMPLOYMENT WORK PHONE

WORK ADDRESS CITY STATE ZIP CODE

PHARMACY NAME PHONE NUMBER

PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN AN EMERGENCY PHONE NUMBER

I hereby authorize payment directly to Dr. Sylvia Zuniga-Barboni of the medical and/or surgical benefits otherwise paid to me but not to exceed the charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance.

Signature:_____

I hereby authorize Dr. Sulvia Zuniga-Barboni to release to my insurance company and/or Primary Care Physician any information acquired, including diagnosis and records in the course of my examination or treatment.

Signature:_____

I hereby authorize any doctor, hospital or medical facility to release records to Dr. Sylvia Zuniga-Barboni.

Signature:_____