BRUCE RABIN MD PHD
Neurology Consultants
Johns Hopkins Regional Physicians

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PATIENT INFORMATION

☐ Male ☐ Female

Last name	First name	MI	Social security #	Date of birth	
Address		City	State	Zip Code	Country of birth
Home phone	Mobile phone	Work phone	Referring doctor		Email address
US Citizen?	Marital Status	Race	Ethnicity	Religion	Mother's maiden name
Occupation	Name of Employer	Employer Address			
Home phone	Mobile phone	Work phone	Referring doctor		Email address
Emergency contact		Daytime phone	Mobile phone	Relationship	
Additional contact		Daytime phone	Mobile phone	Relationship	
Pharmacy name		Pharmacy phone	Pharmacy fax		

INSURANCE INFORMATION

Name of Primary Insurance	Address		City, State. Zip code	☐ Yes ☐ No
Policy number	Group number	Effective date	Phone number	Is Policy holder the patient?
Policy holder last name, first name, MI			Date of birth	Social security #
Address, City, State, Zip code		Relationship to patient		Employer
Name of Secondary Insurance	Address		City, State. Zip code	☐ Yes ☐ No
Policy number	Group number	Effective date	Phone number	Is Policy holder the patient?
Policy holder last name, first name, MI			Date of birth	Social security #
Address, City, State, Zip code		Relationship to patient		Employer

PAYMENT OF BENEFITS

I authorize Bruce Rabin MD PhD, Neurology Consultants, Johns Hopkins Regional Physicians to file insurance claims on my behalf. I authorize payment of benefits directly to Johns Hopkins Regional Physicians. I understand that I am responsible and agree to pay for any balance not covered by my insurance. I will also be financially responsible if I choose to have services that my health plan covers but do not obtain the required referral or authorization from my health plan, or if I choose not to use my health plan and agree to pay for the services myself. If my health plan does not participate with Johns Hopkins Regional Physicians or the services are not covered under my health plan I agree to pay for my care myself.

Patient or patient representative signature — Date

Patient or patient representative print name — Date