MIAMI HEADACHE INSTITUTE

Date: _____

Demographics				
First Name:		Last Name:		
DOB:		SS:		
Address:				
City:		State:	Zip:	
Home Phone:		Mobile Phone:		
Employer:		Work Phone:		
Marital Status:	Married Single	Divorced	E-mail:	

Emergency Contact(s)		
Name:	Relation:	Phone:
Name:	Relation:	Phone:

Spouse Information		
Name:	Phone:	
Address:		
City:	State:	Zip:

Medical Insurance		
Primary Insurance Company:	Member ID:	
Group Number:		
Secondary Insurance Company:	Member ID:	
Group Number:		

Physicians		
Referring Physician:	Phone:	
Address:		
City:	State:	Zip:
Primary Care Physician:	Phone:	
Address:		
City:	State:	Zip:

Authorization to pay benefits: I, hereby authorize payment directly to the undersigned physician of the surgical and/or medical benefits:

Signed (Insured Person):_____Date:_____

MIAMI HEADACHE INSTITUTE
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Coral Gables, FL 33134

Neurology-Electromyography
Phone: 305.440.5969
Fax: 305.476.9441