Eric C. Drew, MD

MD NEUROLOGY

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Phone: 972-219-5397 Fax: 972-219-5609

Billing Information

Patient Name:____

Date of Birth:____________________ Social Security:____________________

Street Address:____

City, State, Zip: ____

Primary Contact Number:____________________________ (cell, home or work)

Secondary Contact Number:__________________________ (cell home or work)

Email:______________________________ (for appointment reminders, emails are never sold or distributed)

Emergency Contact:____

Relation to Patient:_______________ Phone Number: _____________________

How did you hear about us? ____

Primary Care Physician:____

Office Phone:_____________________ Fax:_____________________

Referring Physician:____

Office Phone:_____________________ Fax:_____________________

Pharmacy Name:____

Pharmacy Address:____________________________________ City:_________________

State, Zip:____________________ Phone:________________ Fax:________________

Check one of the following:

○ Self Pay ○ Insurance Coverage? (Please fill out the below information)

Insurance Company:____

Member ID:____________________________ Group ID: ____________________________

Primary Policy Holder Name: ___________________________ DOB:______________________

Relation to Patient:______________________________

Address (if different from patient) ____