

**NEW PATIENT  
INFORMATION RECORD**

**MICHAEL STEIN, M. D.**  
**Neurology**  
**1844 San Miguel Drive, Suite 316**  
**Walnut Creek, California 94596**  
**Telephone (925) 938-5252 FAX (925) 938-1343**

**PLEASE PRINT CLEARLY**

**PATIENT INFORMATION**

PATIENT'S NAME		MARITAL STATUS					DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
		S	M	W	D	SEP			
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY		CITY			STATE		ZIP CODE		
HOME PHONE	BUSINESS PHONE NO.	CELL PHONE NO.		E-MAIL ADDRESS		DRIVER'S LIC NO.			
PATIENT'S A MINOR <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, REMAINDER OF FORM SHOULD BE COMPLETED BY PARENT		OCCUPATION (INDICATE IF STUDENT)							
PATIENT'S EMPLOYER		PHONE NO.		E-MAIL ADDRESS		HOW LONG EMPLOYED?			
EMPLOYER'S ADDRESS		CITY			STATE		ZIP CODE		
SPOUSE'S NAME		HOME PHONE NO.		OTHER RESPONSIBLE FAMILY MEMBER					
SPOUSE'S ADDRESS (IF DIFFERENT)		CITY			STATE		ZIP CODE		
SPOUSE'S EMPLOYER		PHONE NO.		E-MAIL ADDRESS		HOW LONG EMPLOYED?			
NAME OF NEAREST RELATIVE OR FRIEND		HOME PHONE NO.		E-MAIL ADDRESS		RELATIONSHIP			
ADDRESS		CITY			STATE		ZIP CODE		

**REFERRING INFORMATION**

NAME OF REFERRING PHYSICIAN	CITY AND STATE	ZIP CODE	PHONE NO.
PRIMARY CARE PHYSICIAN	CITY AND STATE	ZIP CODE	PHONE NO.
FRIEND OR RELATIVE	CITY AND STATE	ZIP CODE	PHONE NO.

**BILLING INFORMATION** If injury and/or treatment is the result of industrial accident or personal injury, please give name and policy number of responsible insurance company

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE, AND ZIP CODE		PHONE NO.
NAME OF INSURANCE COMPANY	MEMBER ID#	GROUP NUMBER	
NAME OF SUBSCRIBER	RELATIONSHIP TO PATIENT	D.O.B. OF SUBSCRIBER & SOCIAL SECURITY	
NAME OF SECONDARY OR OTHER INSURANCE COMPANY, ADDRESS			
DRIVERS LICENSE NO.	INJURY CAUSED BY ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	MEMBER ID#	PHONE NO.