BAHAMAS NEUROLOGICAL CENTER, INC.
#10 Caves Village, West Bay Street
P. O. Box CR-54258 Nassau, Bahamas
Phone (242) 322-8763 • Fax (242) 322-8764

Patient Information

Last Name:	First: M.I.
Age:	D.O.B:
Sex:	Marital Status:
Referring Physician:	P.O. Box
Home Phone:	Street Address:
Work Phone:	City:
Mobile Phone:	State:
Email:	

Employer/School:	City:
Phone:	Fax:

Next of Kin:	**Relationship:**	D.O.B:
Home Phone:	P.O.Box	
Work Phone:	City:	
Mobile Phone:	Email:	

Next of Kin:	**Relationship:**	D.O.B:
Home Phone:	P.O.Box	
Work Phone:	City:	
Mobile Phone:	Email:	

Insurance Information

Primary Insurance:	Group#:
Insured's Name:	ID#:
Type of Coverage:	Cert#:
Secondary Insurance:	Group#:
Insured's Name:	ID#:
Type of Coverage:	Cert#:

PLEASE TURN FORM OVER

BAHAMAS NEUROLOGICAL CENTER, INC.
At the Parthenon, West Street
P.O. Box CR-54258 Nassau, Bahamas
Phone (242) 322-8763 • Fax (242) 322-8764

Patient Information

CONDITIONS OF MEDICAL TREATMENT

The undersigned agrees that whether he signs as a patient, as an agent of the patient or as a guarantor in consideration of services rendered to the patient by **Dr. Edwin Demeritte/Bahamas Neurological Center/Neurodiagnostics Center of The Bahamas**, he/she hereby obligates him/her self to promptly pay all bills submitted in regards of any such services(s) rendered by **Dr. Edwin Demeritte/Bahamas Neurological Center/Neurodiagnostics Center of The Bahamas**. Bills are due immediately upon issuance. Bills incurred during in-hospital care may be issued as a part of a patient's hospital bill or issued directly by the service provider.

The undersigned authorizes **Dr. Edwin Demeritte/Bahamas Neurological Center/Neurodiagnostics Center of The Bahamas** to disclose all or part of the medical records of the patient named below to such insurance companies, organizations or agencies as may be concerned with the partial or full payment of any bill(s) issued in regards to services received by the patient. The undersigned acknowledges his/her obligation to pay any unpaid portion of such bill(s) covered by such insurance companies.

The undersigned certifies that he has read the foregoing paragraphs and fully understands the legal obligations thereby created and whether as patient, duly authorized agent of the patient or as Guarantor, executes this agreement in full acceptance of its terms.

_____ _____
Print Name of Patient Signature of Patient

_____ _____
Print Name of Agent Signature of Agent (if applicable)

_____ _____
Print Name of Guarantor Signature of Guarantor (if applicable)

_____
Date

CONDITIONS FOR OVERNIGHT PROCEDURES

This procedure may be done at a hotel, hospital or an apartment. The intent for this room is for medical purposes only and should not be considered for any other reason.

All patients that are minors must be accompanied by a parent and/or guarantor in order to facilitate testing.

_____ _____
Signature of Patient Signature of Guarantor (if applicable)

_____
Date