NEAL ALPINER M.D. FAAP, FAAPMR, CLCP
355 Barclay Circle, Suite A
Rochester Hills, MI 48302
Ph 877-433-7767 Fax 877-433-6907
Board Certified Pediatrics, Board Certified PM & R

NEW PATIENT BILLING INFORMATION

Patient Name	**Guarantor's (Policy Holder's) Date of Birth**
Date of Birth (Patient)	Address
Home Phone	Work Phone
Mobile/Cell Phone	Email Address
Patient Employer (or School Name if minor)	Occupation (if applicable)

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Is this an Auto Insurance case? Is this a Worker's Comp case? **PRIMARY** Insurance co. name _____ Policy #_____ Claims Address/Phone _____ __ Effective Date of policy _____ Date of Injury (if applicable) _____ Referral necessary to see a specialist?	If Yes, is Auto Primary or Secondary Is an attorney involved? **SECONDARY** or **AUTO** Insurance co. name _____ Policy #_____ Claims Address/Phone _____ ___ Effective date of policy_____ Date of Injury (if applicable)_____

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If this is an Auto case you must include the adjuster's contact information, claim number and date of accident.

If Auto case please indicate where and when you had prior treatment.

If this is a Worker's Comp case you must include the claim # and address with date of injury.

If there is Attorney on case we must have name and contact info for release of records

Primary Care/Referring PHYSICIAN NAME, ADDRESS, PHONE, FAX- Please provide