

OTOLARYNGOLOGY HEAD & NECK SURGERY

PLEASE PRINT

PATIENT INFORMATION							
LAST NAME OF PATIENT		FIRST		MI	ADDRESS		
CITY		STATE	ZIP CODE	SEX	HOME PHONE	WORK PHONE	DATE OF BIRTH
SOCIAL SECURITY NO.		INDICATE # OF INSURANCE PLANS		DEPENDENTS	MARITAL STATUS () SINGLE () MARRIED () OTHER		
EMPLOYED BY	YEARS	ADDRESS		CITY	STATE	ZIP CODE	TELEPHONE

RESPONSIBLE PARTY STATEMENT		
AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.		
	RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE
	X	

REFERRED BY			
NAME		ADDRESS	TELEPHONE

PERSON RESPONSIBLE FOR PAYMENT (SPOUSE OR PARENT)							
LAST NAME		FIRST			MI	ADDRESS	
CITY	STATE	ZIP CODE	SEX	HOME PHONE	WORK PHONE	DATE OF BIRTH	
SPOUSE EMPLOYER	ADDRESS		CITY		STATE	ZIP CODE	TELEPHONE
FATHER'S EMPLOYER	ADDRESS		CITY		STATE	ZIP CODE	TELEPHONE
MOTHER'S EMPLOYER	ADDRESS		CITY		STATE	ZIP CODE	TELEPHONE

INSURANCE COMPANY INFORMATION									
NAME OF PRIMARY INSURANCE		POLICY NO.	GROUP	NAME OF SECONDARY INSURANCE			POLICY NO.	GROUP	
ADDRESS					ADDRESS				
CITY	STATE	ZIP	TELEPHONE	CITY	STATE	ZIP	TELEPHONE		
NAME & ADDRESS OF INSURED		DATE OF BIRTH	SEX	RELATIONSHIP TO PATIENT	NAME & ADDRESS OF INSURED		DATE OF BIRTH	SEX	RELATIONSHIP TO PATIENT

INSURANCE AUTHORIZATION

1. I hereby authorize payment of medical insurance benefits directly to Otolaryngology Head & Neck Surgery for services rendered.
2. I authorize any holder of medical information about me to release to my insurance company and its agents any information necessary to determine these benefits.
3. I understand that I am financially responsible for all deductibles, coinsurance and non-covered services.
4. I authorize the use of this signature on all my insurance submissions.

PATIENT'S SIGNATURE (OR PARENT)

DATE