



PATIENT INFORMATION

All of the following must be answered fully in order for us to help you with your insurance needs.

DATE: _____

(Please Print)

FIRST NAME: _____

LAST NAME _____

C/O: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE # () _____

CELLPHONE# () _____

DATE OF BIRTH: _____ SEX: M / F

PATIENT'S SS#: _____ AGE _____

MARITAL STATUS: M / S / W / DIV. / SEP.

PARENTS OR GUARDIAN:

Mother: _____ Father: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

TELEPHONE #: _____

EMPLOYER: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE# _____

*PRIMARY CARE DOCTOR / REFERRING DOCTOR:

Dr. Name: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

*POLICY HOLDER _____

SOCIAL SECURITY # _____

*POL.HOLDER DATE OF BIRTH: _____

RELATIONSHIP: SELF: _____

SPOUSE: _____

CHILD: _____

OTHER: _____

*PRIMARY INSURANCE

NAME: _____

POLICY# _____

GROUP# _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CO-PAY: \$ _____ DEDUCTIBLE: \$ _____

SECONDARY INSURANCE

NAME: _____

POLICY # _____

GROUP # _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PRESENT PROBLEM: EAR () NOSE () THROAT ()

MAIN COMPLAINT: _____

MEDICATIONS: _____

ALLERGIES TO MEDICATIONS: _____

SIGNATURE: _____

* Required information