# University Otolaryngology Head and Neck Surgery, Inc.

## Patient Information

| Last Name | First Name | MI | Age | Date of Birth |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____/_____/_____ |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

| Home Phone Number | Cell Phone Number | Marital Status (please circle) | Male/Female Please Circle |
|---|---|---|---|
| _____ | _____ | M S D W | Male/Female |

Social Security Number:_____Employer's Name: _____Phone Number:_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

May we leave a message on your home telephone? YES / NO Physician:_____

## Party Responsible for Payment (if not above or if patient is a minor)

| Last Name | First | MI | Date of Birth |
|---|---|---|---|
| _____ | _____ | _____ | _____/_____/_____ |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

| Social Security Number | Male/Female Please Circle | Home Phone Number |
|---|---|---|
| _____ | Male/Female | _____ |

Employer's Name: _____Employer's Phone Number:_____Ext. _____

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**Primary Insurance:** _____Identification Number_____

Policy Holder's Name: _____Policy Holder's Date of Birth: _____/_____/_____

Patient Relationship to Policy Holder: _____ self_____ spouse_____ child_____ other Copay$_____

**Secondary Insurance:** _____ Identification Number_____

Policy Holder's Name: _____Policy Holder's Date of Birth: _____/_____/_____

Patient Relationship to Policy Holder: _____self _____spouse_____ child _____other Copay$_____

**Primary Care Physician**: _____Telephone:_____

**Referring Physician**: _____Telephone:_____

**Is this a work-related injury? _____ No _____Yes If Yes: Claim #**_____

Insurance Company Name & Address: _____

Attorney Name: _____Attorney's Phone Number: _____

**I consent to treatment necessary for my care. I authorize the release of all medical records to the physicians involved in my treatment and to my insurance company, if applicable. I allow fax transmittals of my medical records, if necessary. I acknowledge full financial responsibility for services rendered at this facility. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.**

**Patient (Guardian) Signature**_____**Date** _____/_____/_____