HEAD & NECK SURGICAL GROUP

PATIENT INFORMATION

Patient Name: _____ Soc. Sec. #: _____

Address: _____ Apt _____ City: _____

State: _____ Zip: _____ Date of Birth: _____ Age: _____

Home Phone: (___) _____ Work Phone: (___) _____

Cell Phone: (___) _____ E-Mail Address _____

Sex: M F Marital Status: S M D W □ Employed □ Student □ Retired

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: (___) _____

PERSON AUTHORIZED TO SPEAK ON YOUR BEHALF

Name: _____ Relationship: _____ Phone: (___) _____

PREFERRED PHARMACY **Phone (___) _____ Fax (___) _____**

Name: _____

Address: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone: (___) _____

Address: _____

WHO REFERRED YOU TO THIS OFFICE?

Referring Physician Name: _____ □ Friend (Name): _____

□ Health Insurance Company □ Website □ ZocDoc □ Other _____

INSURANCE INFORMATION

	#1	**#2**
Insurance Company		
Policyholder Name		
Insured's Birthdate, SS#		
Relationship to Patient		
Co-Pay Amount		

Head & Neck Surgical Group's Notice of Privacy Practices has been provided. I authorize the release of medical information necessary to coordinate care, communicate with referring physicians and to process insurance claims. In accordance with medical treatment, there may be procedures or tests performed at additional cost. I authorize direct payment of covered benefits to the provider of professional services. The patient is responsible for all fees, regardless of insurance coverage. If your insurance requires a referral and it is not obtained the day of the visit, you will be responsible for all charges. Payment for office visits is expected at the time of service.

Date: _____ Patient Signature: _____