



# OSBORNE HEAD & NECK institute

Date:

## Patient Information

<b>Last Name:</b>		<b>First Name:</b>		<b>Middle Initial</b>	<b>Date of Birth</b> / /	<b>Age:</b>
<b>Address ( No PO Box Please)</b>			<b>City</b>	<b>State</b>	<b>Zip</b>	
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>		<b>Email</b>		
<b>Social Security #:</b>	<b>Marital Status:</b> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>				<b>Sex:</b> M <input type="checkbox"/> F <input type="checkbox"/>	
<b>Spouses Name:</b>			<b>Home Phone:</b> _____ <b>Cell Phone</b> _____			
Do we have permission to leave messages that may include medical information for you at this number?						Y <input type="checkbox"/> or N <input type="checkbox"/>
<b>Employer:</b>			<b>Occupation:</b>			
<b>Address:</b>			<b>City</b>	<b>State</b>	<b>Zip</b>	
Please state the medical problem we are treating today:.						
_____						
_____						
Have you sought legal advice for this problem? Yes <input type="checkbox"/> or No <input type="checkbox"/>						
<b>Primary Care Physician:</b>						
<b>Address:</b>			<b>City</b>	<b>State</b>	<b>Zip</b>	
<b>Phone</b>			<b>Fax</b>			

## Insurance Information

Please give your Insurance Card to the receptionist

<b>Primary Insurance</b>	<b>Policy #</b>	<b>Group #</b>	<b>Secondary Insurance</b>	<b>Policy#</b>	<b>Group#</b>
<b>Claims Address:</b>		<b>Co Pay:</b>	<b>Claims Address:</b>		
<b>City</b>	<b>State</b>	<b>Zip</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Subscriber's Name:</b>		<b>Date of Birth:</b>	<b>Subscriber's Name:</b>		<b>Date of Birth:</b>
<b>Relationship to Insured:</b> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			<b>Relationship to Insured:</b> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		

## How Did You Hear About Us?

<b>Website</b> <input type="checkbox"/>	<b>Family</b> <input type="checkbox"/>	<b>MD</b> <input type="checkbox"/>	<b>Hospital</b> <input type="checkbox"/>	<b>Ins</b> <input type="checkbox"/>	<b>Friend</b> <input type="checkbox"/>	<b>Other</b> <input type="checkbox"/>
<b>Referring Physician:</b>			<b>Address:</b>			
<b>Phone:</b>			<b>Fax:</b>			

**Emergency Information**

<b>Emergency Contact:</b>	<b>Relationship</b>	<b>Home#:</b>	<b>Cell#</b>
<b>I authorize the release of any medical information necessary to process my insurance claim(s). I authorize the release of my medical information to my referring or treating physician. I hereby authorize my Insurance Company(s) to pay directly to Osborne Head and Neck Institute or IE Surgical, the medical or surgical benefits of any otherwise payable for services as described on my insurance form hereof, but not to exceed the charges for those services. I the undersigned understand that I am financially responsible for those medical and/or surgical charges incurred by me, or my dependant. All fees necessary to collect this account are payable by me</b>			
<b>Signature of Patient/Legal Guardian</b>			<b>Date:</b>