Date:

Patient Information

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

Insurance Information

Please give your Insurance Card to the receptionist

Primary Insurance	Policy #	Group #	Secondary Insurance	Policy#	Group#
Claims Address:		Co Pay:	Claims Address:		
City	State	Zip	City	State	Zip
Subscriber's Name:	**Date of Birth:**		**Subscriber's Name:**	**Date of Birth:**	
Relationship to Insured: Spouse ☐ **Child** ☐ **Other** ☐			**Relationship to Insured:** Spouse ☐ **Child** ☐ **Other** ☐		

How Did You Hear About Us?

Website ☐ Family ☐ MD ☐	Hospital ☐ Ins ☐ Friend ☐ Other ☐
Referring Physician:	Address:
Phone:	Fax:

Emergency Information			
Emergency Contact:	**Relationship**	**Home#:**	**Cell#**
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			
Signature of Patient/Legal Guardian			**Date:**