



Full Legal Name \_\_\_\_\_ Age \_\_\_\_\_

Birthdate \_\_\_\_\_ Status S M W D Sex \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street (No PO Box Please)

City & State \_\_\_\_\_ Zipcode \_\_\_\_\_

Patient's SS# \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_

**PRIMARY CARE PHYSICIAN** \_\_\_\_\_ Phone \_\_\_\_\_

**REFERRED BY** \_\_\_\_\_ Phone \_\_\_\_\_

**PARENT/GUARDIAN or SPOUSE**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Last First M.I.

Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Social Security No. \_\_\_\_\_

**EMERGENCY CONTACT PERSON**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**\*\*INSURANCE INFORMATION-PLEASE COMPLETE IN FULL\*\***

**PRIMARY INSURANCE** \_\_\_\_\_

Insurance ID \_\_\_\_\_ Group No \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_

Insurance ID \_\_\_\_\_ Group No \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ SS# \_\_\_\_\_

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE TREATMENT BY HEAD AND NECK SURGICAL ASSOCIATES AND ASSIGN INSURANCE BENEFITS TO BE PAID TO HEAD & NECK SURGICAL ASSOCIATES. I ACKNOWLEDGE FINANCIAL RESPONSIBILITY FOR BALANCE DUE IN ACCORDANCE WITH MY INSURANCE PLAN.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_