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EAR NOSE & THROAT

Head & Neck Surgery Otorhinolaryngology

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____
(Last) (First) (MI)

Birth date: _____ Age: _____ Sex: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____
(Hispanic or Non-Hispanic)

Home Address: _____
(Street) (Apt. #)

City: _____ State: _____ Zip Code: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Email Address: _____

Emergency contact name: _____ Phone # _____

INSURANCE INFORMATION

PRIMARY	SECOND	THIRD
Name of Insurance Co:	Name of Insurance Co:	Name of Insurance Co:
Name of Insured:	Name of Insured:	Name of Insured:
Date of Birth:	Date of Birth:	Date of Birth:
Insured's SS#:	Insured's SS#:	Insured's SS#:
Insured's Employer:	Insured's Employer:	Insured's Employer:

Primary Care Physician name: **Phone #:**

I hereby authorize Dr. J. Roy Lowry D.O./Dr. Jeremy P. Watkins M.D./Dr. John B. McIntyre M.D. to release any medical information to my insurance company, family physician, or referring doctor. I understand that I am responsible for all charges and full payment is due at time of service, including my co-pay. If my insurance plan requires a referral authorization and no authorization is provided, I understand that I am responsible for the charges. I will notify the office of any changes that occur such as address, phone number, family doctor and insurance plan. I understand that when my insurance changes from one HMO to another that my previous referral is void. I must contact my family physician to get another referral under my new plan. I understand that if I fail to notify the office of changes, I will be held accountable for those charges. I authorize Dr. J. Roy Lowry D.O./Dr. Jeremy P. Watkins M.D./Dr. John B. McIntyre M.D./office to file my insurance on my behalf. In the event that my insurance company does not pay for any of the services provided, I understand that I am responsible for the charges.

_____ _____
(Signature) **(Date)**

Complete only if patient is a minor	
Mother /Guardian Name:	Father/Guardian Name:
Date of Birth	Date of Birth
Address	Address
Home Phone	Home Phone
Work Phone	Work Phone