PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Gender: _____ Race: _____ Ethnicity: _____ Marital Status: _____

SSN: _____ Preferred Language: _____ Primary Phone: _____

Alternate Phone: _____ Email Address: _____

Employer: _____ Is Patient a Student?_____ Name of School: _____

Family Physician: _____ Referring Physician: _____

Reason for Appointment: _____

Date of First Symptoms: _____ Is Condition Related to Work? _____ Accident? _____

If PATIENT is a MINOR, please complete the following:

Mother's Name: _____ Father's Name: _____
Mother's Address: _____ Father's Address: _____
_____ _____
Mother's Employer: _____ Father's Employer: _____
Mother's Phone: _____ Father's Phone: _____

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL, PLEASE BE SURE TO OBTAIN YOUR REFERRAL PRIOR TO YOUR APPOINTMENT. PLEASE NOTIFY OUR OFFICE IMMEDIATELY OF ANY CHANGES TO YOUR INSURANCE.

Please provide our office with your insurance card and photo identification at the time of your appointment

Primary Insurance: _____ Name of Policy Holder: _____
Insurance Address: _____ Policy Holder SSN: _____
_____ Policy Holder DOB: _____
Identification#: _____ Policy Holder Employer: _____
Group/Policy#: _____

Secondary Insurance: _____ Name of Policy Holder: _____
Insurance Address: _____ Policy Holder SSN: _____
_____ Policy Holder DOB: _____
Identification#: _____ Policy Holder Employer: _____
Group/Policy#: _____

I request that payment of authorized Medicare/Other Insurance Company benefits be made to me or on my behalf to Otolaryngology Physicians of Lancaster for any services rendered by Otolaryngology Physicians of Lancaster. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

Signature: _____ Date: _____