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Board Certified in Otolaryngology

PATIENT INFORMATION

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Mailing address  
\_\_\_\_\_

Home phone \_\_\_\_\_ Please circle the best number to reach you:  
Home Work Cell

Work phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Cell Phone \_\_\_\_\_ Marital Status \_\_\_\_\_

Race: (Please circle) Ethnicity: (Please circle) Language:  
White Hispanic/Latino \_\_\_\_\_  
American/Alaskan Indian Non-Hispanic/Latino \_\_\_\_\_  
Black/African American Declined or  
Asian Declined  
Native Hawaiian/Pacific Islander  
Other  
Declined

Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer address  
\_\_\_\_\_

Primary care doctor \_\_\_\_\_ Phone \_\_\_\_\_

Referring doctor \_\_\_\_\_ Phone \_\_\_\_\_

Person to notify in case of an emergency and their phone number  
\_\_\_\_\_

Their relationship to you \_\_\_\_\_

**GUARANTOR INFORMATION**

Who carries the insurance? \_\_\_\_\_ DOB: \_\_\_\_\_

SSN#: \_\_\_\_\_ Their relationship to you: \_\_\_\_\_

Employer and address which insurance is through  
\_\_\_\_\_

**\*PLEASE HAVE RECEPTIONIST TAKE A COPY OF YOUR INSURANCE CARD.\***

**\*\*DOES YOUR INSURANCE REQUIRE A REFERRAL?\***

If so, did you get one? Please let the receptionist know.

I authorize payment of medical benefits to Upper Valley Neurology Neurosurgery, PC for all services rendered. I understand I am financially responsible for any balances not fully paid by my insurance company.

I hereby authorize the release of my medical information related to these claims to my insurance company.

*Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

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**If you are being seen due to an accident at work please complete the following:**

**ACCIDENT/WORKERS COMPENSATION INFORMATION**

**Date of accident:** \_\_\_\_\_ **Claim #:** \_\_\_\_\_

Is this a workers compensation injury? (If yes, please indicate **place of employment** in which the accident occurred, their **address**, and **phone number**.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Workers compensation/Liability insurance name, address and phone number:

\_\_\_\_\_  
\_\_\_\_\_