

NEW PATIENT INFORMATION (PLEASE PRINT) DATE _____

PATIENT'S NAME	SS#	MARITAL STATUS					SEX		DATE OF BIRTH	AGE	MOBILE PHONE #
		S	M	W	D	SEP	M	F			
STREET ADDRESS	CITY/STATE/ZIP							HOME PHONE #		WORK PHONE #	
PATIENT'S EMPLOYER	EMPLOYER ADDRESS										
POLICYHOLDER'S NAME	ADDRESS							POLICYHOLDER'S SS #		DATE OF BIRTH	
POLICYHOLDER'S EMPLOYER	POLICYHOLDER'S EMPLOYER ADDRESS								EMP PHONE #		
RESPONSIBLE PARTY (IF DIFFERENT THAN POLICYHOLDER)	HOME PHONE #		MOBILE PHONE #			WORK PHONE #		DATE OF BIRTH			
RESPONSIBLE PARTY ADDRESS	CITY/STATE/ZIP							SS #			
RELATIONSHIP TO PATIENT (IF MINOR)											
DRUG ALLERGIES IF ANY											
EMERGENCY CONTACT:	FRIEND/RELATIVE				ADDRESS				PHONE #		
REFERRING DOCTOR	STREET ADDRESS, CITY, STATE							ZIP CODE		PHONE #	

NAME OF INS. _____

PLEASE PROVIDE YOUR INSURANCE CARD.

PLEASE NOTE: OUR OFFICE POLICY ON DIVORCE SITUATIONS IS THAT THE PARENT THAT BRINGS THE CHILD IN IS RESPONSIBLE FOR THE BILL, REGARDLESS OF THE DIVORCE DECREE.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BUSINESS OFFICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE SAN ANTONIO HEAD & NECK SURGICAL ASSOC., P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE _____ SIGNATURE _____