Mile High Otolaryngology, LLC

PATIENT INFORMATION SHEET

Today's Date____________

Patient Name ____

Date of Birth_________________Age_____ Sex_____ Marital Status ___________

Parent/Spouse Name____

Mailing Address____

City_________________State_____________ Zip_______________________________

Home Phone___________________ Work Phone____________________________

Cell Phone_________________________ SS# _________ - _____ - ___________

Referring Physician ________________Employer __________________________

Email address____

Auto Injury Y/N Work Comp Y/N Claim #______________________________

Date of Accident__________________

INSURANCE INFORMATION

Does Patient Have Insurance Yes / No. If yes, complete the rest of form.

***All of the questions below are regarding the policyholder NOT the Patient.**

Primary Insurance____

Policyholder's name____

(If different from above)

Address____

Daytime Phone Number_____________________ Date of Birth________________

Policyholder's SS#__________________ Employer___________________________

Policyholder's Marital Status____________________

Patient's relationship to Policyholder________________________________

Secondary Insurance____

Policyholder's Name____

(If different from above)

Address____

Daytime Phone Number_____________________ Date of Birth________________

Policyholder's SS#___________________ Employer_________________________

Policyholder's Marital Status____________________

Patient's relationship to Policyholder__________________________________

Emergency Contact

Name__________________________________Phone #________________________

Relationship to Patient____

I authorize the release of any information required to process claims, utilization review and quality assurances for services rendered and hereby assign my insurance benefits to be paid directly to my physician.

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Signature of Patient or Guardian **Date**