MANHATTAN OTOLARYNGOLOGY-HEAD & NECK SURGERY

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NAME_____ DATE OF BIRTH_____/_____/_____

ADDRESS_____ SSN_____

_____ HOMEPHONE#_____

CITY_____STATE_____ZIP_____ CELL PHONE#_____

EMPLOYER_____ WORK PHONE#_____

ADDRESS_____ WORK FAX#_____

_____ OCCUPATION_____

PHARMACY NAME_____ EMAIL_____

PHARMACY PHONE_____

POLICY HOLDER'S NAME_____ SSN_____

ADDRESS_____ RELATIONSHIP TO PATIENT:

_____ _____

D.O.B (OF PRIMARY INSURANCE HOLDER) _____/_____/_____

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

ADDRESS_____ ADDRESS_____

PHONE#_____ PHONE#_____

POLICY ID#_____ POLICY ID #_____

GROUP#_____ GROUP#_____

POLICY HOLDER_____ POLICY HOLDER_____

REFERRED BY_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE #_____ FAX#_____

PRIMARY PHYSICIAN_____PHONE_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMERGENCY CONTACT_____PHONE#_____

ADDRESS_____CITY_____STATE_____ZIP_____

Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. If the doctor participates in your insurance plan, the patient is required to pay all the applicable co-pays at the time of the visit. In the event that the account is turned over for collection, the collection, the collection fee and/or legal fees shall be your responsibility.

I understand that I am financially responsible for any amount not covered by the contract.

I hereby assign all the medical and/or surgical benefits, Medicare. Private insurance and other health plans, to the treating physician. Among those listed above. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment to be considered as valid as an original. I hereby authorize the release of all information necessary to the necessary to the Healthcare Facility Administration and other in orders to secure payment.

_____ _____

SIGNATURE DATE