OHIO HEAD & NECK SURGEONS

(Please Print)

Patient Information

REGISTRATION FORM

Patient Name _____

Patient Address _____ Telephone No. ( ) _____

City _____ State _____ ZIP Code _____ Cell No. ( ) _____

Patient Social Security Number_____ Marital Status Married ☐ Single ☐ Div ☐ Sep ☐ Widow

Patient Sex F M Birthdate_____ Age_____ STUDENT ☐ Yes ☐ No

IS THE PATIENT CURRENTLY EMPLOYED? Yes ☐ No ☐ SCHOOL _____

Patient's Employer _____

Address _____ Telephone No. ( ) _____

IMPORTANT ALTERNATE PERSON TO CONTACT _____

FRIEND OR RELATIVE NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY Telephone No. ( ) _____

IF PATIENT IS UNDER AGE 18, PARENT OR LEGAL GUARDIAN MUST COMPLETE AND SIGN THIS SECTION IN ORDER TO AUTHORIZE MEDICAL CARE BY OUR PROVIDERS.

Custodial Parent Name: _____

Signature _____ Date _____

WERE YOU REFERRED BY ANOTHER DOCTOR? **(Please Check One)** ☐ Yes ☐ No

Referring Doctor: _____ **Phone ( )**_____

Primary Care Doctor: _____ **Phone ( )**_____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our financial policy for details.

Primary Insurance

Cardholder Name: _____

Address: _____

City _____ State _____ ZIP Code _____

Phone: _____ Soc. Sec. No. _____

Birthdate: _____ Marital Status: _____

Employer: _____

Employer Address: _____

Insurance Address: _____

Insurance Co.: _____

Policy #: _____ Group #: _____

Effective Date _____

Relation to Patient: Spouse ☐ Father ☐ Mother ☐

Other _____

Secondary Insurance

Cardholder Name: _____

Address: _____

City _____ State _____ ZIP Code _____

Phone: _____ Soc. Sec. No. _____

Birthdate: _____ Marital Status:_____

Employer: _____

Employer Address: _____

Insurance Address: _____

Insurance Co.: _____

Policy #: _____ Group #: _____

Effective Date _____

Relation to Patient: Spouse ☐ Father ☐ Mother ☐

Other _____

May we contact you at work? ☐ Yes ☐ No

May we leave appointment and other reminders on your answering machine? ☐ Yes ☐ No

The Practices' Notice of Privacy Practices has been made available to me. ☐ Yes ☐ No

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize **OHIO AND NECK SURGEONS, INC.** to furnish information to insurance carriers concerning my illness and treatment and hereby assign to the physician(s) all payments for medical services to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature _____ Date _____