**Date** _____

PATIENT'S NAME _____
First Middle Last Name you go by

HOME PHONE _____ CELL PHONE _____

ADDRESS _____
Street, P.O. Box or Route & Box No. City State Zip

_____
**(If College Student, list parent address.)** **(If P.O. Box or Route & Box used, please list street, city and state of residence here.)**

SEX ❑ M ❑ F MARITAL STATUS ❑ S ❑ M ❑ D ❑ W PATIENT'S BIRTHDATE _____ AGE _____

SOCIAL SECURITY NUMBER _____

STUDENT ❑ FULL-TIME ❑ PART-TIME DISABLED ❑ Y ❑ N OCCUPATION _____

PATIENT'S EMPLOYER _____ PHONE _____

YOUR EMPLOYMENT STATUS ❑ FULL-TIME ❑ PART-TIME ❑ RETIRED RETIREMENT DATE _____

FAMILY DOCTOR _____ REFERRING DOCTOR _____ CITY _____

HOW DID YOU FIND OUT ABOUT US? _____

SPOUSE NAME _____ SPOUSE SOCIAL SECURITY _____

EMPLOYER _____ PHONE _____ BIRTHDATE _____

SPOUSE EMPLOYMENT STATUS ❑ FULL-TIME ❑ PART-TIME ❑ RETIRED RETIREMENT DATE _____

**IS THE PATIENT ALLERGIC TO ANY MEDICATION OR LATEX? ❑ Y ❑ N IF YES, PLEASE LIST THEM** _____

_____

## ****** IF PATIENT IS UNDER AGE 18, PLEASE COMPLETE BELOW ******

**MOTHER OR GUARDIAN NAME** _____

SOCIAL SECURITY NO. _____ BIRTHDATE _____

ADDRESS _____

EMPLOYER _____

WORK PHONE _____ HOME PHONE _____

**FATHER OR GUARDIAN NAME** _____

SOCIAL SECURITY NO. _____ BIRTHDATE _____

ADDRESS _____

EMPLOYER _____

WORK PHONE _____ HOME PHONE _____

● ● ● ● ● ● **MORE INFORMATION NEEDED ON REVERSE SIDE** ● ● ● ● ● ●

**PERSON TO CONTACT WHO IS NOT AT YOUR ADDRESS** _____

RELATIONSHIP _____ PHONE _____

**IS THIS VISIT FOR AN ACCIDENT?** ❑ Y ❑ N IF YES, WHAT TYPE? ❑ HOME ❑ AUTO ❑ WORK ❑ OTHER _____

DATE OF ACCIDENT _____ STATE WHERE ACCIDENT HAPPENED _____

IF ACCIDENT INSURANCE COMPANY _____

CLAIM OR POLICY NO. _____ CONTACT PERSON _____

ADDRESS _____ PHONE _____

_____

_____

_____

**PRIMARY INSURANCE** _____ POLICYHOLDER _____

ADDRESS _____ POLICYHOLDER DATE OF BIRTH _____

ID NO. _____ GROUP NO. _____

**SECONDARY INSURANCE** _____ POLICYHOLDER _____

ADDRESS _____ POLICYHOLDER DATE OF BIRTH _____

ID NO. _____ GROUP NO. _____

I hereby authorize Cleveland Head and Neck Clinic, PC to furnish your insurance company(s) all information which said insurance company(s) may request. I hereby assign Cleveland Head and Neck Clinic, PC all money to which I am entitled for medical and/or surgical expense relative to the service rendered, but not to exceed my indebtedness to the professional corporation. It is understood that any money received for the above named insurance company(s), over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible to the said corporation for charges not covered by this assignment. The undersigned waives all rights of exemption under the laws of the State of Tennessee. I agree to pay all collection costs and a reasonable attorney fee if I fail to promptly pay this account when due.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cleveland Head and Neck Clinic, PC for any services furnished by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare or Medicaid and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made on my behalf to Cleveland Head and Neck Clinic, PC for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer (_____) and information needed to determine these benefits.

Patient (if over age 18) or Parent/Guardian Signature _____ Date _____