HNSA

PATIENT REGISTRATION

HEAD+NECK
SURGICAL ASSOCIATES

PATIENT INFORMATION

Name ______________________________ Social Security No. ______________ DOB __________
Last First M.I.

Home Address ____
Street City State Zip

Mailing Address (if different) ____

Sex M F Marital Status M S D W O Home Ph (___) ______________ Cell Ph (___) ______________

Employer's Name ______________________________ Work Phone (___) ______________

Referring Doctor ______________________________ Phone (___) ______________

Primary Care Doctor ______________________________ Phone (___) ______________

PERSON RESPONSIBLE FOR PAYMENT

Name ______________________ Relationship to patient ______________ Soc. Sec. No. ______________
Last First M.I.

Date of Birth ______________ Address (if different) ____
Street City State Zip

Home Phone (___) ______________ Employer ______________________ Phone (___) ______________

SPOUSE OR PARENT (IF MINOR, PARENT OTHER THAN LISTED ABOVE)

Name ______________________________ Relationship ______________
Last First M.I.

Address ____
Street City State Zip

Home Phone (___) ______________ Work Phone (___) ______________

EMERGENCY CONTACT (OTHER THAN LISTED ABOVE)

Name ______________________ Relationship ______________ Phone No. (___) ______________
Last First M.I.

Address ______________________________ Work Phone. (___) ______________
Street City State Zip

MEDICAL INSURANCE (NEED COPY OF CARD)

Primary Insurance ______________ Group No. ______________ ID No. ______________

Insured Name ______________ Relationship to patient ______________ Employer ______________

Secondary Insurance ______________ Group No. ______________ ID No. ______________

Insured Name ______________ Relationship to patient ______________ Employer ______________

OTHER INFORMATION

Pharmacy Name: ____

Pharmacy Phone Number: ____

Pharmacy Address: ____

WORKER'S COMPENSATION COMPANY / MVA:

Case Worker Name: ______________________ Phone: (___) ______________

Company Name: ______________________ Claim No. ______________

I hereby authorize my physician to release any medical information necessary to process claims with any insurance companies. I also assign my physician all payments to which I am entitled for medical and surgical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee. ❑ Privacy Notice.

X ____
SIGNATURE ❑ UPDATE RELATIONSHIP TO PATIENT DATE

X ____
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X ____
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