

Please Complete & Bring to Appointment

PATIENT INFORMATION SHEET

Account # _____ Date _____

Patient Name _____ Age _____ Sex _____

Address _____ City _____ St _____ Zip _____

Home Phone # _____ Birthdate _____ SS# _____

Marital Status _____ Occupation _____

Employer _____ Work Phone # _____

Spouse or Parent's Name _____ SS# _____

Date of Birth _____ Occupation _____

Employer _____ Work Phone # _____

GUARANTOR INFORMATION

Guarantor's Name _____ Age _____ Sex _____

Address _____ City _____ St _____ Zip _____

Home Phone # _____ Birthdate _____ SS# _____

Employer _____ Work Phone # _____

Person not living in same household to contact in case of an emergency _____

Address _____ Phone # _____ Relationship _____

Referring Physician _____

How did you hear about McCalla Ear Nose and Throat? _____

Is this injury/illness work related? _____

Do you have any infectious diseases which can be transmitted to another person? _____

I authorize payment of medical benefits to undersigned physician for services rendered.

Signature (insured or authorized representative)

INSURANCE INFORMATION

Primary Insurance Co. _____ ID# _____

PolicyHolder _____ Group# _____

Secondary Insurance Co. _____ ID# _____

PolicyHolder _____ Group# _____