

CENTRAL JERSEY OTOLARYNGOLOGY, LLC

PATIENT INFORMATION PLEASE PRINT

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

PATIENT'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ WORK _____ SEX (M) (F)

DATE OF BIRTH ____/____/____ AGE _____ PATIENT'S HEIGHT _____ PATIENT'S WEIGHT _____

SOC .SEC. # _____ - _____ - _____ MARITAL STATUS S M D W (PLEASE CIRCLE ONE)

RACE _____ ETHNICITY _____ PREFERRED LANGUAGE _____

REFERRING DOCTOR/PRIMARY DOCTOR _____ PHONE # _____

PHARMACY _____ PHONE # _____

PARENT OR GUARDIAN _____

ADDRESS _____

STREET

CITY/STATE

ZIP

EMERGENCY CONTACT: _____

INSURANCE INFORMATION WORKERS COMP? YES NO AUTO? YES NO ACCIDENT DATE _____

NAME OF INSURED/SUBSCRIBER _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ - _____ - _____

PRIMARY INSURANCE COMPANY _____ PHONE # _____

ID# _____ GROUP # _____

ADDRESS _____

STREET

CITY/STATE

ZIP

SECONDARY INSURANCE CO. _____ PHONE _____

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ SOC SEC # _____

ID# _____ GROUP # _____

PLEASE NOTE: INSURANCE CONTRACTS ARE MADE BETWEEN YOU AND THE INSURANCE COMPANY. WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT THE CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY. PAYMENT OF ANY CHARGES ARE PRESUMED TO BE YOUR RESPONSIBILITY.

I HEREBY AUTHORIZE CENTRAL JERSEY OTOLARYNGOLOGY, LLC TO FURNISH INFORMATION CONCERNING MY ILLNESS AND TREATMENT TO MY INSURANCE COMPANY, ATTORNEY, SCHOOL, OR OTHER TREATING PHYSICIAN.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I UNDERSTAND THAT CENTRAL JERSEY OTOLARYNGOLOGY, LLC REQUIRES PAYMENT AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN AGREED UPON.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____