HEAD & NECK SURGICAL ASSOCIATES

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1 Burnside Drive, Wichita Falls TX 76310
Telephone No: (940) 322-6953

NOTE: To avoid a $25.00 cancellation fee, please give us 24 hours advanced notice when cancelling appointments.

PERSONAL INFORMATION

Today's date:_____ **PATIENT'S SSN**:_____

(PATIENT)
First Name:_____ MI: _____ Last Name:_____

Address:_____

Zip Code:_____ City:_____ State:_____

Date of Birth: ___/____/_____ Age:_____ Gender:_____ Marital Status: _____
Height: _____

Minor Patients: Name of Parent/Guardian:_____

Full Time Student? o Yes o No

Preferred Language:_____ Are you Hispanic/Latino **(ethnicity)**? o Yes o No

Race: O African/American O Asian O White O other (list)_____

May we leave information on your answering machine, e-mail, or voicemail? o Yes o No

Home phone number: (_____)_____ Cell Number: (_____)_____

Work number: (_____)_____

Employer: _____

In the event of an emergency, please contact:

NAME: _____

RELATIONSHIP: _____ Phone Number: (____) _____

Referring Physician's Name:_____ Phone No: (____)_____

Family Physician/PCP: _____ Phone No: (____)_____

REASON FOR YOUR VISIT:

OVER PLEASE

HEAD & NECK SURGICAL ASSOCIATES

1 Burnside Drive, Wichita Falls TX 76310

INSURANCE INFORMATION

Please present your insurance card(s) to the receptionist for her to scan.

Please give complete information:

NAME OF PATIENT:_____ Date of Birth:_____

PRIMARY INSURANCE

INSURANCE CO:_____Policyholder's Name:_____

PATIENT'S relationship to policyholder: **O** Self, **O** Spouse, **O** Child, **O** Other

Policy Number: _____Group Number: _____

Employer: _____

Policyholder's SSN:_____ Date of Birth:_____

SECONDARY INSURANCE

INSURANCE CO:_____Policyholder's Name:_____

PATIENT'S relationship to policyholder: **O** Self, **O** Spouse, **O** Child, **O** Other

Policy Number:_____ Group Number:_____

Employer:_____

Policyholder's SSN:_____ Date of Birth:_____

The parent/guardian accompanying a child will be responsible for all charges.

I have read the above information, and understand and agree that I am responsible for payment of services I receive:

PATIENT/Guardian Signature: _____Date:_____

***Health Ins. Portability & Accountability Act: Please list family member(s)/friend to whom we may release medical information*:**

_____ _____

_____ _____

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