

CAPITAL REGION OTOLARYNGOLOGY Head & Neck Group, LLP

****Patients must complete all necessary paperwork prior to being seen by the provider****

Date: _____

Social Security Number: _____ - _____ - _____

PATIENT NAME: _____ **Date of Birth** ____/____/____ **Age:** _____

Previous Last Name: _____

Sex: Male / Female **Marital Status:**(circle one) Never Married Married Separated Widowed Divorced

Address: _____

Street Address City State Zip Code

Email address: _____@_____

Home Phone: (____)____-____ **Work Phone:** (____)____-____ **Cell Phone:** (____)____-____

Preferred Contact Method:

Office Calls:(check one) Home Phone Work Phone Cell Phone Portal

Appointment Reminders:(check all preferences) Call: Home or Cell Email Text Message

Government Requested Questions:

Race: (check one): () White () Black/African American () American Indian/Alaska native
() Asian () Hawaiian/Pacific Island () Declined/unknown

Ethnicity:(check one) () NOT Spanish/Hispanic origin () Spanish/Hispanic origin () Declined/Unknown

Language: Primary: _____ (Country) _____ Secondary: _____ (Country) _____

Pharmacy & Doctors:

Pharmacy Name & Phone #: _____

Mail Order Pharmacy: _____

Primary Care Physician: _____

Address: _____ **Phone:** _____ **Fax:** _____

Name of Physician who referred you today: _____

Address _____ **Phone:** _____ **Fax:** _____

Other Medical Providers you are currently seeing that would be relevant to your care:

Name (Specialty) Address Phone # Fax #

Name (Specialty) Address Phone # Fax #

Employer:

Employer Name: _____ **Address:** _____

Occupation: _____

Spouse's Name _____ **Phone:** _____

Spouse's Employer & Address: _____

Occupation: _____

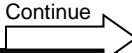
Emergency Contact:

Name: _____

Relationship: _____ **Cell Phone:** (____)____-____

Home Phone: (____)____-____

Work Phone: (____)____-____

Continue 

Complete for Child:

Parent 1 Name: _____ **SSN:** _____ - _____ - _____

Address: _____
Street Address City State Zip Code

Date of Birth _____ Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Employer: _____ Address: _____

Occupation: _____

Is Father responsible for the child's bills? (Circle one) Yes / No

Parent 2 Name: _____ **SSN:** _____ - _____ - _____

Address: _____
Street Address City State Zip Code

Date of Birth _____ Home #: (____) _____ Cell #: (____) _____ Work #: (____) _____

Employer: _____ Address: _____

Occupation: _____

Is Mother responsible for the child's bills? (Circle one) Yes / No

Insurance Information:

IS THIS A WORKERS COMPENSATION CASE OR NO FAULT CLAIM? (Circle one) **YES / NO**

Are you currently covered by insurance? (Circle one) Yes / No

Does your primary insurance have a deductible? (Circle one) Yes / No

If yes, has the deductible been met for the current year? (Circle one) Yes / No

PRIMARY INSURANCE INFORMATION:

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____ Co-pay: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____ DOB: _____

Policy Holder's Employer: _____ Address: _____

SECONDARY INSURANCE INFORMATION:

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____ Co-pay: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____ DOB: _____

Policy Holder's Employer: _____ Address: _____

If no insurance, Driver's License Number: _____