THE CENTER FOR
Voice & Swallowing Services

Unsurpassed capabilities. Subspecialty skill. Complete care.

DATE: _____

PATIENT INFORMATION:

Name:_____ Male:_____ Female:_____

Address:_____ Apt#:_____

City:_____ State: _____ Zip Code:_____

Home Phone:_____ Date of Birth: _____/_____/_____

Work Phone:_____ Social Security #: _____-_____-_____

Cell Phone: _____ Marital Status: S M W

Employer Name:_____ Race_____ Ethnicity_____ ☐ Declined

Reason For Visit?: _____Pharmacy #_____

ADDITIONAL INFORMATION:

How were you referred to this practice? _____

Who is your Primary Care Provider (PCP)? _____

PCP Phone & Location: _____

Emergency Contact Name & Phone: _____

Friends or Family seen by our practice: _____

RESPONSIBLE PARTY/PRIMARY INSURANCE INFORMATION: (from insurance card)

Company: _____

Telephone: _____ Policy Holder's Name: _____

Policy Holder's ID: _____ Group ID: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN: _____-_____-_____

Copay: _____ Effective Dates: _____

Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION: (from insurance card)

Company: _____

Telephone: _____ Policy Holder's Name: _____

Policy Holder's ID: _____ Group ID: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's SSN: _____-_____-_____

Copay: _____ Effective Dates: _____

Relationship to Patient: _____

I authorize the release of any medical information necessary to process this claim and all future claims. I also authorize payment of medical benefits directly to the physician.

X_____ Date:_____/_____/_____

I understand that payment in full is required at the time of service, unless my physician is a provider for my insurance plan or I have made financial arrangements with the business office. I also understand that it is my responsibility to inquire as to whether or not my physician is a provider for my health insurance plan prior to being seen.

X_____ Date:_____/_____/_____