ARKANSAS OTOLARYNGOLOGY CENTER & AOC SURGERY CENTER

PATIENT INFORMATION **Date:_____**

Patient Name: _____/_____/_____
LAST FIRST MIDDLE

Address: _____
STREET APARTMENT CITY STATE ZIP

Home Ph. (____)_____ Cell Ph. (____)_____ Patient Soc. Sec. #: _____

Date of Birth: _____ Age: _____ Sex: ☐M ☐F Marital Status: ☐S ☐M ☐W ☐D

Ethnicity: ☐Hispanic or Latino ☐Not-Hispanic or Latino // Preferred Language: ☐English ☐Spanish ☐Other _____

Race: ☐White/Caus. ☐African American ☐Am.Indian or Alaskan ☐Asian ☐Hawaiian or Pac.Islander ☐Other_____

Patient's Employer: _____ Occupation: _____

Work Ph. (____)_____ Optional Email address: * _____

** Please only provide your Email address IF you authorize us to send your appointment reminders to your Email.*

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Business Phone (____)_____

IF PATIENT IS A MINOR, COMPLETE MOTHER & FATHER INFORMATION

Mother's Name: _____ Father's Name: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Employer: _____ Employer: _____
Home # :(____)_____ Work # :(____) _____ Home # :(____)_____ Work # :(____)_____

IN CASE OF EMERGENCY: Name of a relative/friend not living at same address:
Name: _____ Relationship: _____ Phone: _____
Has any FAMILY member been a patient here? []No []Yes- _____ _____ _____
Name of Family Member Relationship Approx. when?

PHARMACY & Address_____

Did a doctor send you to our clinic: ☐ **YES--Doctor Name & City: _____** ☐ **NO**

Who is your Primary Care Doctor? ☐ **Same as Above -or- List Name _____**

INSURANCE INFORMATION

PRIMARY* CO.:_____ ☐ Medicare-Advantage ☐ PPO ☐ HMO Effective Date: _____

Insurance Co. Address: _____
STREET SUITE # CITY STATE ZIP

Policyholder's SSN: _____ Insurance Phone #: (___) _____

Policy #: _____ Group #: _____

Policyholder's Name: _____ Birthday: _____ Sex: ☐ Male ☐ Female

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SECONDARY* CO.: _____ ☐ Medicare-Advantage ☐ PPO ☐ HMO Effective Date: _____

Insurance Co. Address: _____
STREET SUITE # CITY STATE ZIP

Policyholder's SSN: _____ Insurance Phone #: (___) _____

Policy #: _____ Group #: _____

Policyholder's Name: _____ Birthday: _____ Sex: ☐Male ☐Female

*IF TRICARE: ☐Prime-need referral ☐Standard ☐Tricare for Life Service Branch: _____ ☐ Active ☐ Retired

ACCIDENT INFORMATION: Accident Related to: ☐Work ☐Auto ☐Other_____ Date: _____Time:_____ ☐ AM ☐ PM

PAYMENT AUTHORIZATION: I request that payment of authorized Medicare/Medicaid (or any other Insurance or Third Party) benefits be made on my behalf to Arkansas Otolaryngology Center for any services furnished me by these physicians or other authorized healthcare providers. I authorize any holder of medical information about me to release to Medicare/Medicaid (or any other Insurance or Third Party) any information needed to determine these benefits or the benefits payable for related services. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MEDICARE/MEDICAID OR ANY OTHER THIRD PARTY PAYER. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

SIGNATURE: _____ **DATE** _____

(This form must be COMPLETED and SIGNED before you can see the Doctor.)

Revised 02.10.2012
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