Dr. Michael Freedman

Ear, Nose, Throat, Allergies & Facial Plastic Surgery

Patient Information Form

Account ______________________ Date ______________________

Patient

Last Name ______________ First Name ______________ Middle ______________
Street Address ______________________ Apt. # ______________
City ______________ State ______________ Zip Code ______________
Home Phone (____) ______________ Work Phone (____) ______________ Cell Phone (____) ______________
Date of Birth ______________ Last 4 Digits of SS# ______________ Age ______________ Sex M F
Driver's License # ______________________ Marital Status ______________
Email ____
Employer ______________________ Employer Phone # ______________
Employer Address ______________________ City ______________ State ______________
Spouse's Name ______________________ Spouses Employer ______________
Employer Address ______________________ Employer Phone # ______________
Friend or relative not living with you ______________ Phone # (____) ______________
Pharmacy Name ______________________ Phone # (____) ______________

How did you hear about our office?

- ☐ Family / Friend
- ☐ Family Doctor
- ☐ Internet / Google
- ☐ Billboard
- ☐ Insurance Referral

Insurance Information

Primary Insurance Co. ______________________ Policyholder Name ______________
Policyholder Birthdate ______________
Secondary Insurance Co. ______________________ Policyholder Name ______________
Policyholder Birthdate ______________

Guarantor Information (for minor children only)

Name ______________ Street Address ______________________
City ______________ State ______________ Zip Code ______________
Home Phone ______________ Relationship to patient ______________ Occupation ______________

Have you had any recent testing (MRI, CT scan, etc.) for head or neck? If possible, please bring copy of report.
Yes ____ **No** ____ **If yes, where and when** ______________________

I understand, acknowledge, and agree that I am responsible for payment of any health care services provided to the extent not covered by my health insurance, for the reason I did not have a referral (authorization) from my primary care physician.

I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I hereby authorize the release of any information acquired in the course of my examination or treatment to my insurance company.

Your signature below indicates your consent for treatment of/as patient and responsibility for paying the bill.
I hereby authorize the payment of medical benefits directly to the physician.

Signature ______________________ Date ______________________