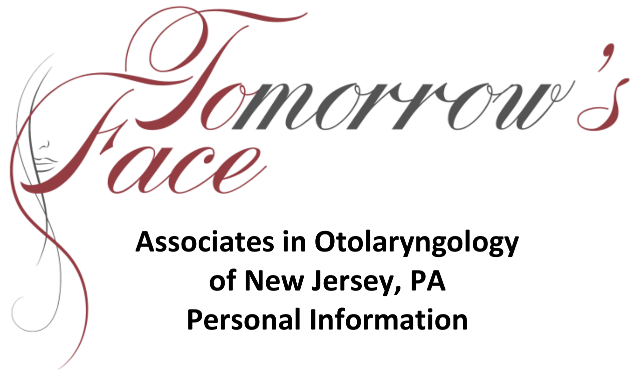

Associates in Otolaryngology
of New Jersey, PA
Personal Information

Name:________________________________ Date of Birth: ____________ Age:_________

Home Address: (Street address only, no P.O. boxes)

____________________________________ City: ________________ State: ____ Zip:_______

Home phone: __________________ Work: _________________ Cell: ___________________

Male/Female (M/F) ______

Are you a student? Yes ___ No ___ If yes, please indicate full time or part time ___________

Marital Status: Married: ___ Single: ___ Widowed: ___ Divorced: ___

Social Security #: _____-_____-________

Employer name: ____

Employer address:
____________________________________ City:_________________ State:____ Zip:_______

Emergency contact name: ___________________________ Phone number: ______________

Primary Care Physician (full name): ____

Address: ____ Phone: _______________

Guardian/Spouse/Partner Information

Name: __________________________________Date of Birth: ________________Male/Female

(M/F) ______

Home Address: (Street address only, no P.O. boxes)

____________________________________ City: ________________ State: ____ Zip:_______

Home phone: __________________ Work: _________________ Cell: ___________________

Social Security #: _____-_____-________ Relationship to Patient:______________

Employer name: ____

Employer address:
____________________________________ City:_________________ State:____ Zip:_______

Employer phone #: _____________________

Primary Insurance

Name of Insurance: ____________________________

ID#:_____________________ Group#: _____________

Policy holder (insured): ________________________________

Relationship to patient:______________________

Policy holder's date of birth: ______________ Policy holder's SSN: _____-____-____________

Employer name:____

Secondary Insurance

Name of Insurance: ____________________________

ID#:_____________________ Group#: _____________

Policy holder (insured): ________________________________

Relationship to patient:______________________

Policy holder's date of birth: ______________ Policy holder's SSN: _____-____-____________

Employer name:____

Private Insurance Authorization of Benefits/Release:
I, the undersigned, authorize payment of medical benefits to Associates in Otoarlyngology of New Jersey, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to

release my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

____ _________________________
Patient/parent or guardian signature (if child is under 18 years of age) Date

Medicare Lifetime Signature on file:
I request that payment of authorized Medicare benefits be made on my behalf to Associates in Otolaryngology of New Jersey, PA for any services furnished me by the physician. I authorize the holder of medical information about me to release any information to the Health Care Financing Administration and its agents to determine the benefits payable for related services.

____ _________________________
Patient signature Date