CAPITAL REGION OTOLARYNGOLOGY

Head & Neck Group, LLP

Date: _____

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

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

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

Address:_____
_____
Street Address City State Zip Code

Email address: _____@_____

Home Phone: (___)_____-_____ **Cell Phone:** (___)_____-_____ **Work 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 #

_____

Emergency Contact:

Name:

_____

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

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Continue ⇨

Complete for patients under the age of 18:

Primary Guardian's Name: _____ **Relationship**: _____

Address:

_____

Street Address City State Zip Code

Home #: (_____)_____ Cell #: (_____)_____ Work #: (_____)_____

Secondary Guardian's Name: _____ **Relationship:** _____

(If different from above) Home #: (_____)_____ Cell #: (_____)_____ Work #: (____)_____

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: _____

Group Number: _____ Co-pay:_____ Effective Date: _____

Policy Holder (if other than patient): _____ DOB: _____

SECONDARY INSURANCE INFORMATION (If applicable):

Plan Name: _____ I.D. Number: _____

Group Number: _____ Co-pay:_____ Effective Date: _____

Policy Holder (if other than patient): _____ DOB: _____