MILE HIGH
OTOLARYNGOLOGY

Todd W. Beatty, M.D.
Sarmad Sabour, M.D.
Jennifer Winters, Au.D., CCC-A, FAAA

PATIENT INFORMATION SHEET

Patient Name _____ Date _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Parent/Spouse Name _____

Mailing Address _____

City _____ State _____ Zip _____

Phone _____ SS# _____

Referring Physician _____ Employer _____

Email address _____ ☐ Check here to receive educational marketing materials.

Auto Injury ☐ Yes ☐ No Work Comp ☐ Yes ☐ No Claim# _____ Date of Accident _____

INSURANCE INFORMATION

Does Patient Have Insurance ☐ Yes ☐ No *If yes, complete the rest of form.*

**All of the questions below are regarding the policyholder NOT the Patient.*

Primary Insurance _____

Policyholder's name (If different than above) _____

Address _____

Phone Number _____ Date of Birth _____

Policyholder's SS# _____ Employer _____

Policyholder's Marital Status _____ Patient's relationship to Poilcyholder _____

Secondary Insurance (If different from above) _____

Address _____

Phone Number _____ Date of Birth _____

Policyholder's SS# _____ Employer _____

Policyholder's Marital Status _____ Patient's relationship to Poilcyholder _____

EMERGENCY CONTACT

Name _____ Phone # _____

Relationship to Patient _____

I authorize the release of any information required to process claims, utilization review and quality assurances for services rendered and hereby assign my insurance benefits to be paid directly to my physician.

_____

Signature of Patient or Guardian