MILE HIGH
OTOLARYNGOLOGY

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PATIENT INFORMATION SHEET

Patient Name _____ Date _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Parent/Spouse Name _____

Mailing Address _____

City _____ State _____ Zip _____

Phone Number _____ SS# _____

Email Address _____ ☐ Check here to opt-out of email marketing.

How did you hear about us? _____ Referring Physician _____

Auto Injury ☐ Yes ☐ No Workers' 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 from 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 Number _____

Relationship to Patient _____

_____

Signature of Patient or Guardian

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.