Welcome to our practice. Please fill out the information found below to the best of your ability.

Patient's Name			Date of Birth	Age
Street			Home Phone #	
City	ST	ZIP	Soc. Sec. No.	

Marital Status: ❒ Married ❒ Divorced ❒ Single ❒ Widowed SEX: ❒ Male ❒ Female

Personal Email Address:

SPOUSE INFORMATION Spouse's Name	Date of Birth	Soc. Sec. No.

EMPLOYMENT INFORMATION

Patient's Employer	Work Phone #	ext.
Employer's Address	Cell Phone #	
Spouse's Employer:	Work Phone #	ext.
Address:	Cell Phone #	

Emergency Phone Number____________________________________ May we contact you at work? ______________

PHARMACY INFORMATION

Name ____ Phone ____

Allergies ____

INSURANCE INFORMATION

PRIMARY INSURANCE

DO YOU HAVE ❒ Group coverage through your employer ❒ Group through your Spouse's Employer

❒ Medicare ❒ Individual policy

❒ Other (Please List) ____

Please provide your policy information in the space below:

Insured
Insurance Company
Address
Insurance Supplement or Policy Number

PROCEDURE ADVISEMENT - Due to the nature of some of your or your dependent's presenting symptoms it is possible that the doctor will need to perform a diagnostic or therapeutic procedure in order to accurately and successfully diagnose and/or treat your or your dependent's condition. These services are billed separately and may be classified as surgery by some insurance carriers. Additionally, many primary sinus surgery procedures have planned and staged therapeutic post operative surgical procedures which are also separately billable, and are not included in the global fee for the primary surgery.

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

I authorize T. L. Wood, MD FACS to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to T. L. Wood, MD FACS.

I understand that I am financially responsible for all charges incurred.

Date ___________________________________ Signature ____

Who may we thank for referring you: ____