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Sinus and Nasal Surgery
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PATIENT INSURANCE FORM

Name: _____ Date of Birth _____ / _____ / _____
Gender (check one) Male_____ Female_____ Marital Status (check one) Single_____ Married_____

Home Address_____ SSN_____
_____ Home Phone# _____
City_____State_____ Zip_____ Cell Phone# _____
Email _____
Employer: _____ Work# _____
Occupation_____

Policy Holder's Name: _____ SSN_____
Phone number _____ Date of Birth _____ / _____ / _____
Relationship to Patient _____

Primary Insurance: _____ **Secondary Insurance:** _____
Address _____ Address_____
_____ _____
Phone# _____ Phone# _____
Policy ID# _____ Policy ID# _____
Group# _____ Group# _____
Policy Holder_____
Referred by:_____

Primary Physician:_____
Address _____ City _____ State ____ Zip _____
Phone# _____ Fax# _____

Primary Pharmacy:_____ Phone number: _____ Zip _____

Emergency Contact: _____ Phone# _____
Address_____ City _____ State ____ Zip _____

Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. If the doctor participates in your insurance plan, the patient is required to pay all the applicable co-payments at the time of visit. In the event that the account is turned over for collection, the collection fee and/or legal fees shall be your responsibility.

I understand that I am financially responsible for any amount not covered by the contract.

I hereby assign all the medical and/or surgical benefits, including major medical benefits, Medicare. Private insurance and other health plans, to the treating physician listed above. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment to be considered as valid as an original. I hereby authorize the release of all information necessary to the necessary Healthcare Facility Administration and others in order to secure payment.

Date: _____ **Signature:** _____