BRIAN HUMPHREYS, M.D., F.A.C.S.
OTOLARYNGOLOGY

# PATIENT INFORMATION

## PATIENT INFORMATION (THE PERSON SEEING THE PHYSICIAN):

**Name**
Last: ______________________ First: ______________________ M.I. ________

**Address**
Street/Route: ______________________ Age: ________
City: ______________________ State: ____________ Zip: ____________
Phone: (____) ______________________ S.S. # ______________________ D.O.B. ____________
Employer ______________________ Phone: (____) ______________________
Street/Route: ______________________
City: ______________________ State: ____________ Zip: ____________

**May we call you at work? Y / N** **May we leave a message on your answering machine? Y / N**
**Is the patient a student? Y / N** **Full-time? Y / N**

## EMERGENCY CONTACT (SOMEONE NOT LIVING IN THE HOME):

**Name**
Last: ______________________ First: ______________________ M.I. ________
Phone: (____) ______________________ Relationship to Patient: ______________________

## PRIMARY INSURED (THE PERSON WHO CARRIES THE INSURANCE):

Primary Insurance ______________________
Which hospital do you/insurance prefer? ☐ Woodland Heights ☐ Memorial

**Name**
Last: ______________________ First: ______________________ M.I. ________

**Address**
Street/Route: ______________________
City: ______________________ State: ____________ Zip: ____________
Phone: (____) ______________________ S.S. # ______________________ D.O.B. ____________
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other ______________________
Employer______________________ Phone: (_____)______________________
Hospital Required: ______________________
Primary Care Physician: ______________________
Referring Physician: ______________________

**Does this insurance require a referral? Y / N**

## SECONDARY INSURANCE (MUST HAVE COPY OF THE CARD):

Insurance Name: ______________________

**ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL RECORDS**

I, THE UNDERSIGNED AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BRIAN F. HUMPHREYS, MD, FACS, PA, FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CONTRACT. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY OR THEIR AGENT INFORMATION CONCERNING MY HEALTH CARE, ADVICE, TREATMENT, OR SUPPLIES PROVIDED TO ME. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS OF BENEFITS.

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SIGNATURE