NECK______

PATIENT INFORMATION

Patient Name:____ Date: _____/_____/_____
(Last First M.I.)

Patient Address: ____

City _______________ State ____________ Zip ________ Social Security #: (last 4 digits): ___-___-___-___

Home Telephone: _______________ Work Telephone: ___________ Cell Number:___________

Birth date: _____/_____/_____ Sex: ☐F ☐M Height:_______ Weight:__________ Age:_______

Referring Physician: ____________________________ Phone: ____________________________

Address:____________________________________ Fax:______________________________

Primary Care Physician:_______________________ Phone:______________________________

Address:____________________________________ Fax:______________________________

Patient's Employer:_____________________________ Occupation: _________________________

Employer's Address:____________________________ Telephone:__________________________

<u>Emergency Contact</u> (night of test)

Name: ____________________________ Relationship to patient:________________________

Home Telephone:_______________ Work Telephone:_______________ Cell Number: _______________

I hereby authorize payment from my insurance carriers(s) and the release of medical and financial information that may be necessary for billing or government regulatory agencies. I further agree photocopies of this form are to be as valid as the original. If necessary the doctor or staff may check my credit history. I understand that my insurance may or may not pay all charges for services rendered for my care and that I am personally responsible to pay any and all unpaid charges for today's service and future services. I have read and verified that the above information is correct.

Patient:____________________________ Patient:____________________________
(Signed Name) *(Printed Name)*

Guarantor signature if patient under 18:____________________________ Date: ____/____/___