Ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg Date: _____

1708 Fall Hill Avenue, Suite 100, Fredericksburg, Virginia 22401
282 Choptank Road, Suite 107, Stafford, VA 22554
4701 Spotsylvania Pkwy, Suite 100, Fredericksburg, VA 22408

PATIENT INFORMATION **PHONE NUMBERS**

Patient Name: _____ Home: _____

Last **First** **Middle** Cell: _____

Address Street: _____ Work: _____

Mailing: _____ Email: _____

City, State, Zip: _____ Ethnicity: _____ Religion: _____

Sex: [ ] M [ ] F Birth Date: ___/___/___ Pref Contact Method: Cell/Home/Work/Email/Text (**circle one**)

[ ] Single [ ] Married [ ] Divorced [ ] Widow Patient Social Security: _____

Referring Physician: _____ PCP, If Different: _____

Pharmacy Name: _____ Address: _____ Tel#: _____

In Case of Emergency, Please Contact:

Name: _____ Relationship: _____

Phone: _____ Work Phone: _____

If Patient is an adult:

Employer: _____ Spouse's Name: _____

Occupation: _____ Birthday: ____/____/____

Address: _____ Social Security _____

_____ Employer/Phone_____

If Patient is a minor:

Father/Guarantor: _____ Mother/Guarantor: _____

Social Security: _____ Social Security _____

Birth Date: ____/____/____ Birth Date: ____/____/____

Employer/Phone: _____ Employer/Phone: _____

INSURANCE SUBSCRIBER: [ ] SELF [ ] SPOUSE [ ] FATHER [ ] MOTHER [ ] GUARANTOR

I authorize the release of medical information to my insurance carrier(s) and authorize insurance payments directly to Ear, Nose & Throat & Facial Plastic Surgery Center of Fredericksburg. I agree to pay for any/all rendered services that are not covered by my insurance company and if my account becomes delinquent, I assume responsibility for all collection costs, including agency fees (33 1/3% on top of principal balance), court costs, and attorney fees. I authorize the use of this signature on all insurance submissions.

_____ _____ Date: ____/____/____

Responsible Party Signature Relationship

PHOTOCOPY OF THIS FORM SHALL SERVE AS ORIGINAL