

LAWRENCE OTOLARYNGOLOGY ASSOCIATES, P.A.

PATIENT INFORMATION

PATIENT NAME:	SEX:	
SOCIAL SECURITY #:	DATE OF BIRTH:	AGE:
ADDRESS:	MARITAL STATUS:	RACE:

HOME PHONE #:	WORK #:	FAX #:
CELL #:	PAGER#:	E-MAIL:
EMPLOYER:	JOB TITLE:	EMP. PHONE #:
STUDENT?: NO FULL-TIME PART-TIME		

LAST REF. DATE	REFERRING PHYSICIAN/TYPE	REFERRING PHYSICIAN S ADDRESS	TELEPHONE

CONTACTS			
NAME / RELATIONSHIP	ADDRESS / HOME PHONE	JOB TITLE / EMPLOYEER / WK PHONE	COMMENTS

INSURANCE POLICIES						
POLICY #	EFFECTIVE DATE	INS'D NAME	INSURANCE PLAN NAMES	TYPE	GROUP	REQ.AUTH.

SIGNATURE:	DATE:
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Insured/cardholder name and date of birth: _____

Required field

I hereby authorize Lawrence Otolaryngology Associates, P.A. to disclose any or all information they deem necessary to the following people:
 Name: _____ Address: _____ Relationship: _____

This authorization expires upon written notice from the patient. I understand I have the right to revoke this authorization in writing except to the extent Lawrence Otolaryngology Associates, P.A. has taken action or has relied upon the authorization. This authorization may be revoked in writing delivered to Lawrence Otolaryngology Associates, P.A. The information disclosed under this authorization may be subjected to re-disclosure by the recipient and no longer protected under federal privacy laws.

Signature of patient: _____ **DOB:** _____ **Date:** _____

Signature of authorized representative: _____ **Date:** _____ **Relationship:** _____

In order to comply with federal regulations regarding your privacy and still be able to provide you with quality medical care, we request that you specify how you may be contacted by our staff. By checking the ways below you are giving permission for our staff to contact you in the following ways:

- | | |
|---|---|
| <input type="checkbox"/> On my home answering machine at: _____
<input type="checkbox"/> at my work voice mail at: _____
<input type="checkbox"/> On my cell phone voice mail at: _____ | <input type="checkbox"/> At my work at: _____
<input type="checkbox"/> On my cell phone at: _____
<input type="checkbox"/> At my e-mail address at: _____ |
|---|---|