

Bay Area Ear Nose and Throat Associates

John Hammerick, M.D., F.A.C.S.



Patient Contact Information

Patient Name: _____	Spouse Name: _____
Address: _____	
City: _____ State: _____ Zip: _____	
Phone Home: _____ Work: _____ Ext: _____	Phone Home: _____ Work: _____ Ext: _____
Sex: M or F Marital Status: _____	
Social Security Number: _____ - ____ - ____	Social Security Number: _____ - ____ - ____
Date of Birth: __/__/__ Age: _____	Date of Birth: __/__/__ Age: _____
Employer and Address: _____	Employer and Address: _____
Occupation: _____	Occupation: _____

If Patient is a Minor:

Mother's Name: _____	Father's Name: _____
Social Security Number: _____ - ____ - ____	Social Security Number: _____ - ____ - ____
Date of Birth: __/__/__ Age: _____	Date of Birth: __/__/__ Age: _____
Employer and Address: _____	Employer and Address: _____
Phone Work: _____ Ext: _____	Phone Work: _____ Ext: _____
Occupation: _____	Occupation: _____

Patient's Family Physician: _____
Who referred you: Doctor/Friend/Relative: _____

Emergency contacts and to whom we can release medical information to. Please list relationship to patient.

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Insurance Information

Primary: _____ Secondary: _____
Employer: _____ Employer: _____
Insured's Name: _____ Insured's Name: _____

I authorize the release of any medical information necessary to process an insurance claim and request payment under the medical insurance program be made to me or to Bay Area Ear, Nose & Throat Associates (If benefits assigned) on any bill for services rendered by that provider. I am the responsible party for the above stated patient and will be responsible for any denied insurance claims.

Signature: _____ **Date:** _____