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- Pediatric & Adult Otolaryngology
- Head and Neck Surgery

New Patient Questionnaire

Patient Information:

Full name: _____ *Patient number (office use only):* _____

Date of birth: _____/_____/_____ Gender: _____

Next of kin: _____ Relationship to patient: _____

Next of kin phone number: (____) ____ - _____

Patient Contact Information:

Primary phone number: (____) ____ - _____

Cell number (if different): (____) ____ - _____

Street address: _____

City: _____ State: _____ Zip code: _____

Email address: _____

Person Responsible for the Account (if different from patient):

Name: _____ Relationship to patient: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Primary phone number: (____) ____ - _____

Secondary phone number: (____) ____ - _____

Pharmacy Information:

Name of pharmacy: _____

Address of pharmacy: _____

_____

Pharmacy phone: (____) ____ - _____

Employer Information:

Employer: _____

Work phone number: (____) ____ - _____

Insurance Information:

Insurance Company: _____ Policy Number: _____

Name of Primary Account Holder: _____ Group Number: _____

Secondary Insurance Company: _____ Policy Number: _____

Name of Primary Account Holder: _____ Group Number: _____

Financial information: *I understand that should my account be turned over to collections that I am responsible for all fees and cost incurred therein including but not limited to collection fees, and attorney costs. I agree that Hanover, Henrico, or Chesterfield counties shall be appropriate jurisdictions.*

I hereby certify that the information provided above is correct and true to the best of my knowledge.

_____ _____

Patient's Signature (if 18 or older) Parent, Guardian, or Responsible Party Signature

_____/_____/_____

Date