Crawford & Fitch – Ear, Nose and Throat

Today's Date: _________________

Name:____

Address:____

____

Date of Birth:_________________Sex:_______Social Security #:_________________

Phone: Home_______________Work________________Cell___________________

Patient Employed by:____

Emergency Contact Person:__________________________Phone #:______________
Relationship:__________________________

Primary Health Insurance Information

Insurance Company Name: _______________________Employer:_______________
Subscriber's Name:_______________________Subscriber's SS#:________________
Relationship to Patient:__________________Date of Birth:_____________________

Secondary Health Insurance Information

Insurance Company Name:________________________Employer:_______________
Suscriber's Name:________________________Subscriber's SS#:_________________
Relationship to Patient:_________________Date of Birth:______________________

Doctor(s) Name and Address (if not local)

1. ____

2. ____

Insurance Authorization:

I verify that the above information is accurate and that these are the only insurances I have in force at this time. I also understand that I am financially responsible for any charges for services rendered by Crawford and Fitch- Ear, Nose, and Throat.

Signature:____Date:_________________