MICHIGAN OTOLARYNGOLOGY SURGERY ASSOCIATES
& MOSA AUDIOLOGY

PATIENT INFORMATION

NAME ______________________________________ AGE _______ DOB ____________ SEX M F

ADDRESS ___________________________________ MARITAL STATUS: S M D W

CITY, ST ___________________________ZIP ________ SOCIAL SECURITY # ________________________

EMPLOYER or RETIRED __________________________ HOME PHONE_______________________________

WORK PHONE __________________________________ CELL PHONE ________________________________

SPOUSE'S NAME _________________DOB ___________ EMPLOYER OR RETIRED ____________________

PRIMARY/FAMILY DR. __________________________ **REFERRED BY DR.** __________________________

Address ____ Address _____________________________________

Phone # ____ Phone # _____________________________________

IF PATIENT IS MINOR: For unaccompanied minors (patients 17 years old and younger), non-emergency treatment may be denied if parental consent to treat the minor does NOT accompany the patient.

FATHER'S NAME ________________________________ MOTHER'S NAME ____________________________

DATE OF BIRTH ___________ SS# _________________ DATE OF BIRTH ___________SS# ______________

EMPLOYER ______________________________________ EMPLOYER _________________________________

WORK OR CELL PHONE _________________________ WORK OR CELL PHONE ______________________

IS VISIT DUE TO AN INJURY? Yes or NO Date of Injury ___________________

WORKER'S COMPENSATION/AUTO INSURANCE NAME ____

ADDRESS ___________________________________ ATTENTION ________________________________

PHONE ______________________________________ CLAIM # __________________________________

COPY OF ALL INSURANCE CARDS REQUIRED

PRIMARY INSURANCE COMPANY NAME ____

SUBSCRIBER NAME _________________________ RELATIONSHIP TO PATIENT __________________

SECONDARY INSURANCE COMPANY NAME ____

SUBSCRIBER NAME _________________________ RELATIONSHIP TO PATIENT __________________

EMERGENCY CONTACT PERSON

NAME ____ RELATIONSHIP __________ PHONE ____________

I hereby authorize Michigan Otolaryngology Surgery Assoc. P.C. & MOSA Audiology (referred to as MOSA hereafter) to furnish my primary and secondary insurance companies including Medicare & Medigap, any information they may request concerning my treatment or information required in the course or my examination or treatment (which may or may not include hospitalization). Furthermore, I hereby authorize payment directly to MOSA. I understand I am financially responsible for all charges that exceed those covered by my insurance and/or until such time as benefits are paid; and for negotiating a settlement on a disputed claim.

SIGNED: ____ DATE: _________________________________