



THE CENTER FOR  
**Voice &  
Swallowing  
Services**

*Unsurpassed capabilities. Subspecialty skill. Complete care.*

**DATE:** \_\_\_\_\_

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Work Phone: \_\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Cell Phone: \_\_\_\_\_ Marital Status: S M W  
Employer Name: \_\_\_\_\_  
Reason For Visit?: \_\_\_\_\_

**ADDITIONAL INFORMATION:**

How were you referred to this practice? \_\_\_\_\_  
Who is your Primary Care Provider (PCP)? \_\_\_\_\_  
PCP Phone & Location: \_\_\_\_\_  
Emergency Contact Name & Phone: \_\_\_\_\_  
Friends or Family seen by our practice: \_\_\_\_\_

**RESPONSIBLE PARTY/PRIMARY INSURANCE INFORMATION: (from insurance card)**

Company: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
Policy Holder's ID: \_\_\_\_\_ Group ID: \_\_\_\_\_  
Policy Holder's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Copay: \_\_\_\_\_ Effective Dates: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION: (from insurance card)**

Company: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
Policy Holder's ID: \_\_\_\_\_ Group ID: \_\_\_\_\_  
Policy Holder's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder's SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Copay: \_\_\_\_\_ Effective Dates: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**I authorize the release of any medical information necessary to process this claim and all future claims. I also authorize payment of medical benefits directly to the physician.**

X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**I understand that payment in full is required at the time of service, unless my physician is a provider for my insurance plan or I have made financial arrangements with the business office. I also understand that it is my responsibility to inquire as to whether or not my physician is a provider for my health insurance plan prior to being seen.**

X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_