HEAD & NECK SURGERY OF KANSAS CITY, P.A.
EAR, NOSE AND THROAT CARE FOR CHILDREN AND ADULTS

College & Nall Building
5370 College Blvd., Suite 100
Overland Park, KS 66211
913-599-4800
1-800-587-7342
FAX 913-599-2992

150 HWY Office
7201 E 147th St. Suite 120
Grandview, MO 64030
913-599-4800
1-800-587-7342
FAX 913-599-2992

Bonner Springs
913 Sheidley, Suite 200
Bonner Springs, KS 66012
913-599-4800
1-800-587-7342
FAX 913-599-2992

PATIENT MUST BE ACCOMPANIED BY AN ADULT IF UNDER 18.

PLEASE PRINT IN BLUE OR BLACK INK ONLY

PATIENT INFORMATION

LEGAL Name: _____ Age: ____ Birth Date: _____ Sex: M F
First Middle Initial Last

Address: _____ City: _____ St: ____ Zip: _____

Home PH: (____)_____ Social Security #: _____ Mar. Status: S M W D Sep

Work PH (_____)_____ Cell PH: (___)_____Employer: _____

Email address of patient or guardian if patient is under 18: _____

Primary Care Physician: _____City_____ Phone #: (_____)_____
First Last

Referring Physician: _____City_____ Phone #: (_____)_____
First Last

ACCIDENT/WORK COMP INSURANCE: (please circle one) A) Employment B) Auto Accident C) Other

Date and State accident occurred: _____ Injury coverage: Yes No

How injury occurred:_____

PRIMARY and SECONDARY insurance information will still need to be completed below.

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ ID/Policy #: _____

Group Name (Employer):_____ Group #: _____

Claims Address: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN:_____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ ID/Policy #: _____

Group Name (Employer): _____ Group #: _____

Claims Address: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN:_____

IN CASE OF EMERGENCY CONTACT: Name _____

Relation to patient: _____ Home #: (__)_____ Cell/Work #: (___)_____

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION OF BENEFITS:

I hereby authorize Head & Neck Surgery of Kansas City, P.A. to release to my primary care physician and/or insurance company any information acquired in the course of my examination or treatment. I hereby authorize payment be made directly to Head & Neck Surgery of Kansas City, P.A. I understand that I am responsible for any and all charges not paid by my insurance. A photocopy of this assignment is to be considered valid as an original.

PATIENT and/or LEGAL GUARDIAN Signature: _____ DATE: _____

Printed Name of Person Signing: _____ Relationship to Patient: _____

HEAD & NECK SURGERY OF KANSAS CITY, P.A.

COMMUNICATION AUTHORIZATION

Patient Name _____ Date of Birth _____

Please communicate with me in the following manner (check all that apply):

___ My home telephone number is: _____

___ OK to leave a message with detailed information
OR
___ OK to leave a message with callback number only

___ My work telephone number is: _____

___ OK to leave a message with detailed information
OR
___ OK to leave a message with call-back number only

___ My cell telephone number is: _____

___ OK to leave a message with detailed information
OR
___ OK to leave a message with call-back number

___ Written communication:

___ OK to mail to my home address

___ OK to mail to my work/office

___ OK to fax to the number provided: _____

You may discuss my healthcare needs with the following individual(s):

Name of Individual	**Relationship to patient:**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient or Legal Guardian Signature Date

HEAD & NECK SURGERY OF KANSAS CITY

Patient Name: **Date of Birth:**

Medications:

Please list your current medications including over the counter medications

Name of Drug	Strength	How Often

Pharmacy:

What Pharmacy do you want to fill any prescriptions?

Pharmacy Name	Address	City State Zip	Telephone

Allergies:

Are you allergic to any drugs?

Drug	Reaction

Surgery:

Please list any surgeries performed

Type of Surgeries	Hospital or Surgery Center	Date

Additional Doctors:

Please list additional Doctors involved in your care:

Name	City	Phone#

Signature of Person completing form

Date Completed