MICHAEL R. MENACHOF, MD, FACS

ADVANCED EAR, NOSE & THROAT

Name _____ **Date** _____
First Last Middle Initial

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Email _____

Any restrictions for contacting you? ❒ No ❒ Yes _____

Age _____ Birthdate _____ SS# _____ Sex ❒ Male ❒ Female

Marital Status ❒ Single ❒ Married to: _____

Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Apt # City State Zip

Policy Holder _____
(If Other than Patient) First Last Middle Initial

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Email _____

Age _____ Birthdate _____ SS# _____ Sex ❒ Male ❒ Female

Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Apt # City State Zip

Primary Insurance Company _____ Ins Phone # _____

Policy # _____ Group # _____

Address _____
Street City State Zip

Secondary Insurance Company _____ Ins Phone # _____

Policy # _____ Group # _____

Address _____
Street City State Zip

Name of Current Primary Physician _____

Who can we thank for referring you to us _____

Emergency Daytime Contact/ relationship _____ / Phone # _____

I understand that office visit charges are payable on the day the service is rendered. I authorize Dr. Menachof to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand my contract is between Dr. Menachof and myself.

Patient Signature: _____ **Date:** _____

Responsible Party Signature: _____

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