



Sharon M. Tomaski, M.D.

Otolaryngologist • Head & Neck Surgeon • Board Certified & Fellowship Trained

Arapahoe Medical Plaza

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PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Name: Patient's Social Security Number: Date of Birth: SEX: M F Marital Status: S M D W Language Preference if not English: Other communication issues? N Y (what) Street Address: Apt. No.: City: State Zip Code: Home phone: Work phone: Cell/Pager number: Email Address: Emergency Contact Name: Emergency Contact Phone:

GUARANTOR/PARENT INFORMATION

Responsible Party Name: Relationship to Patient: Responsible Party Date of Birth: Guarantor's Social Security Number: Guarantor's Address: Apt. No.: City: State Zip Code: Home phone: Cell/Pager number: Employer's Name: Work Phone: Employer's Address: City: State Zip Code:

** PLEASE NOTE WE DO NOT ACCEPT WORKMAN COMPENSATION OR AUTO ACCIDENT CLAIMS**

PATIENT'S INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company's Name: Insurance Address: City: State Zip Code: Phone Number: Name of Policy Holder: Date of Birth: Insurance ID Number: Group Number: Secondary Insurance Company's Name: Insurance Address: City: State Zip Code: Phone number: Name of Policy Holder: Date of Birth: Insurance ID Number: Group Number:

PATIENT'S REFERRAL INFORMATION

Primary Care Physician Phone: Address: City: State Zip Referring Physician Phone: Address: City: State Zip

Please Read and Sign Both Sides of this Form:

I hereby authorize my insurance benefits to be paid directly to Sharon M. Tomaski, M.D. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: Date:

IMPORTANT OFFICE POLICIES

RELEASE OF MEDICAL INFORMATION

I authorize Colorado Adult and Children’s Ear, Nose, and Throat, P.C. to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to Colorado Adult and Children’s Ear, Nose, and Throat, P.C. I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. We accept cash, checks, Visa and MasterCard. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. We reserve the right to charge \$50.00 for a “no show” appointment, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician’s office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____