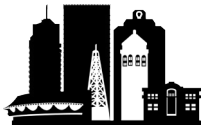

BARTLESVILLE
ENT & Allergy

205 SE Howard Ave.
Bartlesville, Oklahoma 74006

General Information

CHARLES D. HOLLAND, JR., M.D.
MARK A. ROBERTSON, M.D.
REBECCA WILEY, M.D., FACS

Date _____

Patient Name _____ Marital Status ☐ S ☐ M ☐ W ☐ D

Mailing Address _____ City _____ State _____ Zip _____

Cell Phone #: (___) _____ Patient's

Home Phone #: (___) _____ Social Security # _____ Age _____ DOB _____

Patient's Employer _____ Phone # _____

Spouse's Name _____ SS # _____

Employer _____ Phone # _____

COMPLETE IF PATIENT IS A MINOR

Father's Name _____ SS # _____

Employer _____ Phone # _____

Mother's Name _____ SS # _____

Employer _____ Phone # _____

WERE YOU REFERRED BY A PHYSICIAN?

☐ Yes OR ☐ No Name _____

Do you have insurance? ☐ Yes OR ☐ No **POLICY HOLDER'S DATE OF BIRTH** _____

Date of Injury _____ Workman's Compensation ☐ Yes OR ☐ No

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Home Phone (___) _____ Work Phone (___) _____

BENEFITS TO PHYSICIANS

_____ I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS. I ALSO UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

RELEASE OF INFORMATION

_____ I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES.

PHOTOSTAT OF THE ABOVE IS AS VALID AS THE ORIGINAL.

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. MY SIGNATURE INDICATES THAT I HAVE READ THE ABOVE AND GRANT THE REQUEST OF AUTHORIZATION.

_____ _____

Signature Patient/Parent/Guardian Date

I have received a copy of Notice of Privacy Practice

_____ _____

Patient or Legal Representative Relationship

_____ _____

Date Witness