SU WOOI TEOH, M.D., P.A.

ACCOUNT:_____ _____ DATE:_____
PATIENT NAME:_____
(LAST) (FIRST) (MIDDLE)
ADDRESS:_____ _____
(STREET) (CITY) (STATE) (ZIP)
BIRTHDATE:_____AGE:_____SEX:_____SOCIAL SECURITY:_____
HOME PHONE #:_____WORK PHONE #:_____CELL #:_____
EMAIL ADDRESS:_____
WHICH DOCTOR REFERRED YOU?_____
MARITAL STATUS: SINGLE:_____ MARRIED:_____ OTHER:_____ IF STUDENT: _____ _____
(FULL) (PART TIME)
EMPLOYER:_____
(NAME OF COMPANY) (ADDRESS)
IF PATIENT IS A CHILD:
MOTHER'S NAME:_____FATHER'S NAME:_____
MOTHER'S PLACE OF EMPLOYMENT:_____WORK #:_____
FATHER'S PLACE OF EMPLOYMENT:_____WORK#:_____
ARE PARENTS THE CHILD'S LEGAL GUARDIAN:_____
NAME AND ADDRESS OF LEGAL GUARDIAN:_____
_____PHONE NUMBER:_____
SS#:_____DL#:_____PRESENT EMPLOYER:_____
OF YEARS EMPLOYED THERE:_____PHONE #:_____
NAME AND ADDRESS OF NEAREST RELATIVE:_____
PHONE #:_____RELATIONSHIP:_____

INSURANCE INFORMATION

PRIMARY INS. CO. NAME:_____
PRIMARY CARD HOLDER:_____RELATIONSHIP TO PATIENT:_____
ADDRESS OF CARD HOLDER:_____
(STREET) (CITY) (STATE) (ZIP)
PRIMARY CARD HOLDER'S PHONE #:_____WORK #:_____
PRIMARY CARD HOLDER'S DATE OF BIRTH:_____SS#:_____
CERTIFICATE #:_____GROUP #:_____
PRIMARY CARD HOLDER'S EMPLOYER OR SCHOOL:_____

SECONDARY INS. CO. NAME:_____
PRIMARY CARD HOLDER:_____RELATIONSHIP TO PATIENT:_____
ADDRESS OF CARD HOLDER:_____
(STREET) (CITY) (STATE) (ZIP)
PRIMARY CARD HOLDER'S PHONE #:_____WORK #:_____
PRIMARY CARD HOLDER'S DATE OF BIRTH:_____SS#:_____
CERTIFICATE #:_____GROUP #:_____
PRIMARY CARD HOLDER'S EMPLOYER OR SCHOOL:_____
If primary coverage is Medicare, is secondary insurance through your employer?_____Yes_____NO

DO YOU HAVE A THIRD HEALTH INSURANCE POLICY?_____YES _____NO

SIGNED:_____DATE:_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN & RELEASE INFORMATION: I hereby authorize direct payment to my attending physician of medical and/of surgical benefits payable for services provided. I agree to pay any balance which is not paid by insurance. I also authorize Su Wooi Teoh M.D., P.A. to release any information acquired in the course of my examination or treatment to specific, insurance carriers, third party payors, or others involved in processing and collection of any claims.

SIGNED:_____DATE:_____

I understand that Dr. Teoh shares after hours call with other Otolaryngologist's in the Greensboro Community.