PATIENT INFORMATION FORM

Patient's Last Name _____ First Name_____ Middle Initial ____

SSN _____-_____-_____ Date of Birth ____/____/_____ Age _____ Sex: F M Non-disclosed

Address _____ Apt.#_____ City _____ State _____ Zip _____

Race (check one) ◻ *Asian/Pacific Islander* ◻ *Black* ◻ *Native American* ◻ *White* Language: _____

Ethnicity ◻ *Non-Latino* ◻ *Latino* Marital Status: ◻ *Single* ◻ *Married* ◻ *Divorced* ◻ *Widowed* ◻ *Separated*

HOW DID YOU HEAR ABOUT US? _____

Name & Address of Primary Care (Family) Physician / Pediatrician _____

Referring Physician Name & Address (if different) _____

Home Phone (____) _____ Day Phone (____) _____ Cell Phone (____) _____

E-mail Address to Communicate with You _____

Employer: _____ Employer Address: _____

What is or was your occupation? _____ Retired ◻ *Yes* ◻ *No*

Name of Spouse/Parent/Legal Guardian _____ Relationship _____

Home Phone (____) _____ Day Phone (____) _____ Cell Phone (____) _____

PRIMARY MEDICAL INSURANCE

Policy Holder Name _____ SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Customer Service Phone Number _____ Co-pay Amount $_____ Deductible $ _____

SECONDARY MEDICAL INSURANCE

Policy Holder Name _____ SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Customer Service Phone Number _____ Co-pay Amount $_____ Deductible $ _____

I authorize Sinus Solutions, practice of Terrance Kwiatkowski, MD to release information related to this treatment / bill for services to my insurance company, health care companies for my treatment, and / or any information needed for my medical claim(s). I authorize direct payment to Terrance Kwiatkowski, MD, PC for my medical services. I understand that I am financially responsible for charges not covered by my insurance plan / company. I authorize Sinus Solutions, practice of Terrance Kwiatkowski, MD to release my medical records to my family physician, referring physician and current treatment physician. I understand that these records may be sent via electronic channels. I agree that the above information is true and correct to the best of my knowledge and agree to the statements above.

_____ _____ ____/____/_____

Signature of Patient or Authorized Person to Consent Printed Name Date

Terrance J Kwiatkowski, MD 8530 West Sunset Road, Suite 240, Las Vegas, NV 89113 | tel.: 702-966-3100 | fax: 702-966-9909 | SinuSol.com