



The Head+Neck Center  
John U. Coniglio, MD, LLC  
1065 Senator Keating Blvd.  
Suite 240  
Rochester, NY 14618  
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www.RochesterHNC.com

### PATIENT INFORMATION

Please Print, Complete Fully, And Return To The Front Desk

Circle One: Mr. Mrs. Ms. Miss. Dr. Child

Patient Legal Name: \_\_\_\_\_  
Last First Middle

Nickname or Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ (for electronic newsletters)

Name of Spouse/Parent/Legal Guardian: \_\_\_\_\_

Authorization to treat Minor Child: \_\_\_\_\_ Relationship: \_\_\_\_\_

Marital Status (circle one): S M Other Sex: M F

Patient Social Security #: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Person to Notify in Case of Emergency (not at same address) : \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_  
Name Phone

Family Doctor: \_\_\_\_\_  
Name Phone

### INSURANCE INFORMATION

Primary Insurance Carrier: \_\_\_\_\_ Secondary Insurance Carrier: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_

Policy Holders Date Of Birth: \_\_\_\_\_

Policy Holders Subscriber #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policy Holders Employer: \_\_\_\_\_

**Do we have your permission to:**

**Leave a message on your answering machine at home? Yes\_\_\_ No\_\_\_**

**Call or leave a message at your place of employment? Yes\_\_\_ No\_\_\_**

**Discuss your Medical Condition with a member(s) of your family? Yes\_\_\_ No\_\_\_**

**If yes, with whom?\_\_\_\_\_**

**AUTHORIZATIONS**

**I authorize the release of medical records necessary to process insurance claims.**

**I am responsible to pay for all services received regardless of insurance coverage.**

**I authorize payment of medical and surgical benefits to be made directly to The Head + Neck Center.**

**I authorize the release of correspondence and/or medical records to other providers involved in my care.**

**I authorize any holder of medical information about me to release records to The Head + Neck Center.**

**Patient Signature:\_\_\_\_\_ Date:\_\_\_\_\_**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have reviewed and/or received a copy of The Head + Neck Center's Notice of Privacy Practices. This notice describes how The Head + Neck Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of the Notice of Privacy Practices. I understand a copy of the most current version of this practice's Notice of Privacy Practices in effect will be posted in the waiting area.

**Patient Signature:\_\_\_\_\_ Date:\_\_\_\_\_**