CASTELLANO & HOWARD SPECIALTY CENTER

Nelson D. Castellano, M.D.
Facial Plastic-
Ear, Nose & Throat Surgery

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Dominic M. Castellano, M.D.
Facial Plastic-
Ear, Nose & Throat Surgery

Date: _____

Patient's Name: _____ Sex: _____ Married _____
(Last) (First) (Middle) Single _____
Date of Birth: _____ Soc. Sec. No.: _____ Widowed _____
Divorced _____

Phone No.: _____ Email: _____

Address: _____
(Street) (City) (State) (Zip)
Referred By: _____ Insurance Co.: _____

Name of Insured: _____ Group #: _____

Insured Soc. Sec. #: _____ Insured Date of Birth: _____

CONSULTATION REQUESTED BY: _____

****

School/College/Occupation: _____

Employer's Name: _____
(of spouse of you are unemployed)

Employer's Address: _____

Employer's Phone: _____

****

Name of person you would notified in case of emergency:

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Employer: _____

****

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any otherwise payable to me.
AUTHORIZATION FOR INFORMATION: I hereby authorize the undersigned Physician to release/obtain any information acquired/needed in the course of my examination or treatment/or as requested by an insurance company.

Signed: **X** _____ Date: _____

BRIEFLY, what is your chief complaint and its duration? _____

_____

_____

_____

Please list the medications you are now taking and the dosage: _____

_____

_____

ALLERGIES_____

** PRIMARY CARE PHYSICIAN: _____

CONTINUE ON BACK