MICHAEL SETZEN, MD, FACS, FAAP

Nasal & Sinus Surgery • Facial Plastics-Rhinoplasty/Botox/Fillers
Pediatric ENT • Snoring/Sleep Apnea • Reflux/Swallowing/Voice • Laser
Hearing & Balance • Head & Neck • FEESST/Stroboscopy • In-office CT

600 Northern Blvd., Suite 312, Great Neck, NY 11021 • 516.829.0045 • fax: 516.829.0441 • www.michaelsetzen.com

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION **DATE:**

Patient Name: _____ Patient's Social Security Number: _____

Date of Birth: _____ Sex: M ❍ F ❍ Marital Status? S ❍ M ❍ D ❍ W ❍

Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____) _____

Cell/Pager Number: (_____) _____ Email Address: _____

Emergency Contact Name/Relation: _____Emergency Contact Phone: (_____) _____

GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____ _____ _____
(Last) (First) (Middle)

Relationship to Patient: _____ Responsible Party Date of Birth: _____

Guarantor's Social Security Number: _____ -_____- _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell/Pager Number: (_____) _____

Employer's Name: _____ Work Phone: (_____) _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy: Name: _____ Phone: _____

Address: _____ Fax: _____

PATIENT's INSURANCE INFORMATION *Please provide Insurance Card and Photo ID to receptionist

Primary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number (_____) _____

Name of Policy Holder: _____ Date of Birth: _____

Insurance ID Number: _____ Group Number: _____

PATIENT's REFERRAL INFORMATION

Primary Care Physician: _____ Phone (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone (_____) _____

Address: _____ City: _____ State: _____ Zip: _____