



Julie Newburg, M.D.

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CLINIC OF PUEBLO, P.C.

Patient Information

Patient Name _____ Date of Birth _____
Age _____ [] Male [] Female Social Security Number _____

Street Address _____
City/State/Zip _____ E-Mail Address _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____

Marital Status: [] Single [] Married - Spouse's Name _____ [] Widowed [] Divorced
Occupation Status: [] Employed - Employer _____ [] Unemployed
[] Student - School Attending _____ [] Retired

Who referred you to this practice? _____
Who is your Primary Care Physician? _____ PCP Phone # _____
Pharmacy Preference _____ Pharmacy Phone # _____

IF PATIENT IS A MINOR OR STUDENT (Please check [x] the responsible party)

[] Mother's Name _____
Date of Birth _____ Social Security Number _____ Phone # _____
Address, if different than above _____
Mother's Employer _____ Phone # _____

[] Father's Name _____
Date of Birth _____ Social Security Number _____ Phone # _____
Address, if different than above _____
Father's Employer _____ Phone # _____

EMERGENCY CONTACT (Please list someone not listed anywhere else on this form)

Name _____ Relationship _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____
Policy Holder Name _____ SSN# _____
Relationship to Patient _____ Date of Birth _____

Secondary Insurance _____ ID# _____ Group# _____
Policy Holder Name _____ SSN# _____
Relationship to Patient _____ Date of Birth _____

HOW DID YOU HEAR ABOUT ENT CLINIC OF PUEBLO?

[] Referring Physician [] Radio [] Newspaper [] Billboard [] Yellow Book Ad [] DEX Ad [] Hospital _____
[] Referred by Patient; if so, patient's name _____ [] Other _____

PATIENT RELEASE

[] RELEASE: I hereby consent to the release of information provided to or generated by ENT Clinic of Pueblo to my Primary Care Physician, referring physician therapist, attorney, insurance carrier(s), agency or other party with a bona fide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.
[] ASSIGNMENT: I hereby assign medical benefits otherwise payable to ENT Clinic of Pueblo. I understand and agree that I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collection of payment from me. If applicable, I understand I am responsible for all co-pays.
[] VERIFICATION: I hereby verify that all the above information is true and correct as of the date signed below.

Signature _____ Date _____