James P. Thomas, M.D. | voicedoctor.net
Physician & Surgeon – Practice Limited to Laryngology
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Completion of this information in its entirety is required at time of first visit

PATIENT INFORMATION (Please use ink)

_____
First Middle Last

Address _____
Street City State ZIP

Phone _____ Voicemail OK? _____ Social Security # _____/____/_____

Birth Date _____ Gender: _____ Pronouns: _____

Marital Status: Single Married Partnered Widowed

E-mail address _____ Ok for medical correspondence? _____

Employer _____ Occupation _____

How were you referred to this office? _____ Primary Care Physician _____

If someone other than patient is RESPONSIBLE FOR PAYMENT, complete the following:

Name of **responsible party** _____ Address _____

Relationship _____ Social Security # _____/____/_____ Phone _____

Emergency Contact: _____

What will be the FORM OF PAYMENT for your care?

_____ Cash, check or credit card at time of service _____ Dr Thomas will bill health insurance for you; you will pay copay at the time of service

A valid, current insurance card is *required* at the time of service so that we may adequately assist you in billing your insurance.

Primary insurance _____

Subscriber, if not patient _____ DOB_____

Secondary insurance _____

Subscriber, if not patient _____ DOB_____

If you are insured through any Medicare type insurance plan, your insurance requires us to ask you the following question. Please simply check the appropriate response – *Have you filled out an Advanced Directive?* (Please check response) ☐ yes ☐ no