

**EAR, NOSE, THROAT – HEAD & NECK SURGERY OF HUNTSVILLE, P.C.**

201 Whitesport Drive, Huntsville, AL 35801

Phone (256) 881-5353 Fax (256) 881-0712

www.entofhuntsville.com

Mark L. Hagood, M.D.

Shane P. Davis, M.D.

Benjamin D. Powell, M.D.

J. Stephen Brigance, M.D.

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**Referring Doctor:** \_\_\_\_\_

**PLEASE KINDLY PROVIDE YOUR CURRENT INFORMATION:**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email address: \_\_\_\_\_ @ \_\_\_\_\_

***PRIMARY INSURANCE (PLEASE PROVIDE CARD TO RECEPTIONIST TO COPY)***

Carrier: \_\_\_\_\_

Contract No: \_\_\_\_\_

Group No: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

***SECONDARY INSURANCE (PLEASE PROVIDE CARD TO RECEPTIONIST TO COPY)***

Carrier: \_\_\_\_\_

Contract No: \_\_\_\_\_

Group No: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_