Charlene Hickson, M.D. & Esperanza Salazar, M.D.

Pueblo Ear, Nose & Throat Specialist

1218 S. Pueblo Blvd, Pueblo, CO 81005
719-566-1277 (FAX 719-566-1257)

Patient Information

Patient Name _____ Date of Birth _____
Age _____ Social Security # _____ Male or Female _____
Mailing Address _____
City _____ State _____ Zip Code _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Employer's Name _____
Marital Status: Single Divorced Widowed Married Spouse Name _____
Who referred you to this practice? _____
Who is you Primary Care Physician? _____
Primary Care Physician Phone # _____

If the Patient Is a Minor or Student

Mother's Name _____Phone # _____
Mother's DOB _____ Mother's SSN# _____
Address if different than above _____
Mother's Employer _____ Phone # _____
Father's Name _____ Phone # _____
Father's DOB _____ Father's SSN# _____
Address if different than above _____
Father's Employer _____ Phone # _____

Emergency Contact Information (Please list someone that is not listed above)

Name _____ Phone # _____
Relationship _____

Insurance Information

Primary Insurance _____ ID# _____ Group # _____
Policy Holder Name _____ SSN# _____ DOB _____
Relationship to Patient _____ Policy Holder Employer _____
Employer's Address _____ Employer's Phone # _____
Secondary Insurance _____ ID# _____ Group # _____
Policy Holder Name _____ SSN# _____ DOB _____
Relationship to Patient _____ Policy Holder Employer _____
Employer's Address _____ Employer's Phone # _____

Patient Release

Release: I hereby consent to the release of information provided to, or generated by Pueblo Ear, Nose and Throat Specialist, PC to my primary care physician, referring physician, therapist, attorney, insurance carrier(s), agency or other party with a bonafide, 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 be to Pueblo Ear, Nose and Throat Specialist, PC. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collection 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.

Responsible Party Signature _____ Date _____