PATIENT INFORMATION

TODAY'S DATE: **ENT PHYSICIAN:** **MR#**

Patient Last Name	Patient First Name	Middle Initial	Social Security #	Date of Birth	Sex

Patient Street Address	City	State	Zip

Patient Home Telephone #	Patient Cell Phone #	Patient Email Address:

Patient Employer:	Patient Employer Address:	Patient Employer Phone:

Patient Marital Status:	Patient Employment Status (Full Time/Part Time)	Patient Student Status (Full Time/Part Time)

Referring Physician Name:	Referring Physician City/State:	Referring Physician Phone#:

Family Physician Name:	Family Physician City/State:	Family Physician Phone #:

Emergency Contact Person:	Emergency Contact Phone #	Relationship to Patient:

INSURANCE GUARANTOR/CUSTODIAL PARENT ☐same as patient ☐copy of billing statement needed

Responsible Party Last Name	Responsible Party First Name	Middle Initial	Social Security #	Date of Birth

Responsible Party Street Address	City	State	Zip

Responsible Party Home Telephone #	Responsible Party Cell Phone #	Responsible Party Email Address

Responsible Party Employer	Responsible Party Employer Address	Responsible Party Employer Phone #

Relationship to Patient

PRIMARY INSURANCE:		SECONDARY INSURANCE:	
Insurance Co. Name	**Telephone #** ( )	**Insurance Co. Name**	**Telephone #** ( )
Address to Mail Claim		**Address to Mail Claim**	
City State Zip Code		**City State Zip Code**	
Name and Address/City/State/Zip of Insured		**Name and Address/City/State/Zip of Insured**	
Insured Date of Birth	**Insured Social Security #**	**Insured Date of Birth**	**Insured Social Security #**
Group #	**ID #**	**Group #**	**ID #**
Beginning Coverage Date		**Beginning Coverage Date**	

"I consent and authorize the attending physician and/or physicians to give such treatment and care to patient which they deem reasonably necessary and desirable in conjunction with the purpose of visit. I hereby authorize and direct my insurance benefits to be paid directly to Ear, Nose & Throat Assoc., PC./The Surgery Center d.b.a./The Hearing Center. I am financially responsible for any non-covered services. I also authorize the release of any medical information acquired in the course of my examination or treatment to my insurance carrier, or attending physician. I hereby authorize all other physicians and hospitals to release to Ear, Nose & Throat Assoc., PC/The Surgery Center d.b.a./The Hearing Center all medical records for said patient including diagnosis and records of treatment rendered. This authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on this authorization. If not previously revoked, this authorization will expire when Ear, Nose & Throat Assoc., PC ceases rendering medical services to me.

PATIENT SIGNATURE: _____ DATE: _____
OR RESPONSIBLE PARTY SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____
WE FILE ALL MEDICARE CLAIMS FOR OUR PATIENT. PLEASE DO NOT FILE THEM YOURSELF AS OUR PHYSICIANS COULD BE PENALIZED FOR THIS. IF YOUR INSURANCE COMPANY REQUIRES ANY PRE-CERTIFICATION FOR SPECIAL TESTING, X-RAYS, OR SURGERY, IT IS YOUR RESPONSIBILITY TO NOTIFY YOUR INSURANCE CARRIER OF THESE PROCEDURES. THANK YOU.