

E.N.T. SURGICAL ASSOCIATES

PATIENT INFO:

Last Name _____ First Name _____ Middle Initial _____
Home Phone () _____ Work Phone () _____ Ext. _____
Street Address _____
City _____ State _____ Zip _____
Sex _____ Marital Status _____ SS # _____
Birthdate _____ Emergency Phone # () _____ Emergency Name _____
Family Doctor _____
Employer _____
City _____ State _____ Zip _____
Occupation _____ Retirement Date _____
Retired Yes No If yes, supplemental insurance is paid by: SELF / EMPLOYER (please circle one)

RESPONSIBLE PARTY:

Spouse, Parent, Guardian _____ Birthdate _____
Street Address _____
City _____ State _____ Zip _____
Spouse Employer _____ Retirement Date _____
Spouse Occupation _____
Spouse, Parent or Guardian SS # _____
Referred By _____ Retirement Date _____
Retired Yes No If yes, supplemental insurance is paid by: SELF / EMPLOYER (please circle one)

PRIMARY INSURANCE COMPANY

Name _____
Address _____
Numbers _____
Subscriber Name _____
Relationship to Patient: _____

SECONDARY INSURANCE COMPANY

Name _____
Address _____
Numbers _____
Subscriber Name _____
Relationship to Patient: _____

* PLEASE NOTE: The following statement applies to all types of insurance except Medicare.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Therefore, we urge you as the patient, to check with your insurance company prior to any surgery or allergy testing. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred.

Signature _____ Date _____

Witness _____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT

I hereby authorize the above physician(s) to release any information regarding services rendered by them and allow a photocopy of my signature to be used to file my Medicare and/or insurance claim, and any third party payer.

Date

Patient (Parent or Guardian)