EAR, NOSE & THROAT ASSOCIATES

PATIENT INFORMATION

Last Name: _____ First Name _____ MI _____

Address_____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birth Date _____ Age _____ Soc. Sec. # _____ M _____ F _____

Employer _____ Work Phone _____ May we contact you at this # _____

Emergency Contact _____ Phone # _____ Relationship _____

If Married, Name of Spouse _____ Birth Date _____ SSN _____

Spouse's Employer _____ Spouse's Phone # _____

Were you referred by another doctor? Yes _____ No _____ Doctor's Name _____

GUARANTOR (IF UNDER 18 YEARS OLD)

Last Name: _____ First Name _____ MI _____

Address_____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Employer _____

Birth Date _____ Soc. Sec. # _____ M _____ F _____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber Name _____

Address _____ Zip _____

Home # _____ Cell # _____

DOB _____ SSN _____

Employer _____

Relationship to Patient _____

Secondary Insurance _____

Subscriber Name _____

Address _____ Zip _____

Home # _____ Cell # _____

DOB _____ SSN _____

Employer _____

Relationship to Patient _____

WORKER'S COMPENSATION/AUTOMOBILE ACCIDENT

Insurance Company _____ Address _____ Zip _____

Contact Person _____ Phone # _____ Claim # _____

Date of Accident _____ Employer _____ Employer # _____

What Happened? _____

I authorize my insurance company benefits to be paid directly to the physician. I am financially responsible for any balance due. I authorize the physician or insurance company to release any information required for processing this claim.

SIGNATURE _____ **DATE** _____