Ear, Nose & Throat Center, LLP

PATIENT INFORMATION		
PATIENT LAST NAME:		
PATIENT FIRST NAME:		***MI:***
SOCIAL SECURITY NO: ***Male Female***		***DATE OF BIRTH:***
STREET ADDRESS:		
CITY :	*STATE:*	*ZIP CODE:*
HOME PHONE:	***WORK:***	***CELL:***
NAME OF EMPLOYER:	***OCCUPATION:***	
PRIMARY CARE PHYSICIAN:		
E-MAIL ADDRESS:		
EMERGENCY CONTACT NAME:	***PHONE:***	***RELATIONSHIP:***
LANGUAGE:	***ETHNICITY:***	***RACE:***

INSURANCE INFORMATION
PRIMARY INSURANCE:
CARD HOLDER'S NAME AND DOB:
INSURED RELATION:
SECONDARY INSURANCE:
CARD HOLDER'S NAME AND DOB:
INSURED RELATION:

HOW DID YOU HEAR ABOUT OUR PRACTICE?
□ ***FAMILY*** □ ***FRIEND*** □ ***NEWSPAPER*** □ ***PHONE BOOK*** □ ***WEBSITE*** □ ***PHYSICIAN:*** _____   □ ***INTERNET*** □ ***INSURANCE DIRECTORY*** □ ***HOSPITAL*** □ ***OTHER:*** _____

I authorize the release of any medical or other information necessary to process this claim and I direct payment of my insurance benefit to ENT Center, LLP. I will provide necessary information such as referrals, insurance forms prior to my visit. If said information is not provided, I understand I will be held responsible for payment in full at the time of visit.

Signed: _____ Date: _____

Authorization for Medicare patients only

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: _____Date: _____