FAMILY EAR, NOSE AND THROAT CLINIC, P.C.

NAME_____ ___ _____ **SEX: M F Race/Ethnicity**_____
LAST MI FIRST

Preferred Language_____

ADDRESS_____ **Birth Date** ___/___/_____
Street name or PO Box

_____ **SS#:** _____-____-_____
City State Zip Code

Phone #1_____**(home)** **Employer**_____
Phone#2_____**(cell)** **Address**_____
Phone#3_____**(work)** **Work Phone**_____

E-mail address_____

SPOUSE NAME_____ **Birth Date:**___/___/_____ **SSN:**_____-_____-_____

Spouse's employer_____ **Spouse phone number**_____

PARENT NAME#1 (IF MINOR)_____ **Birth Date:** ___/___/_____
Parent employer _____**SSN:**_____-_____-_____

PARENT NAME #2 (IF MINOR)_____ **Birth Date:**___/___/____
Parent employer:_____**SSN:**____-____-_____

PERSON RESPONSIBLE FOR BILL_____ **BIRTH DATE:** ____/____/_____
Relationship to patient_____ **Social Security #** _____-____-_____
PRIMARY INSURANCE COMPANY_____
Employer_____ **Policy ID #**_____
PERSON WHO CARRIES 2ND INS. (if any)_____ **BIRTH DATE:**____/____/_____
SECONDARY INSURANCE COMPANY_____ **Policy ID #**_____

FAMILY DOCTOR_____ **REFERRING DOCTOR**_____
Pharmacy _____**Pharmacy Address**_____

DO WE HAVE PERMISSION TO:

Leave a message on your answering machine @ home with results?	**YES**	**NO**
Leave a message at your place of employment	**YES**	**NO**

IS THERE ANYONE WITH WHOM WE MAY DISCUSS YOUR HEALTH INFORMATION? YES NO
If Yes, whom and relationship_____

AUTHORIZATION TO RELEASE INFORMATION AND INSURANCE ASSIGNMENT
I authorize payment direct to the above named physician(s) of any insurance benefits affording coverage to the named patient but not to exceed the physician's regular fees for such services. I understand that I am financially responsible for all charges. I also authorize the release of such information as may be necessary to the proper authorities.

_____ _____
Signature of patient or parent if minor **Date**