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

NAME____________________ __________________ SEX: M F
Race/Ethnicity______________
LAST FIRST **Preferred**
language________________

ADDRESS____ Birth Date ___/___/______
Street name or PO Box
____ SS#: _____-____-________
City State Zip Code
Phone #1______________________(home) Employer____
Phone#2_______________________(cell) Address____
E-mail________________________ Work phone:_________________

SPOUSE NAME_____________________________________ Birth Date:___/___/_____ SSN:_____-_____-_____
Spouse's employer___________________________________Spouse's phone:______________________

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