Ear, Nose & Throat
Surgical Associates, S.C.

Patient Information Form

Not filling out this form may delay or result in non-payment of insurance benefits, leaving you responsible for services rendered

Last Name _____ First Name _____ MI _____

Maiden Name _____ Social Security # _____ - _____ - _____

DOB _____ / _____ / _____ Age _____ Ethnicity _____ Gender ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ W ☐ D

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Preferred Phone (_____) _____ Secondary Phone (_____) _____

Email _____

Emergency Contact _____ Relationship _____ Phone (___) _____

Referring Physician _____ Primary Care Physician _____

Required for patients under 18 years of age.

Mother/Guardian's Name _____ Phone (_____) _____

Address (if different from above) _____

Father/Guardian's Name _____ Phone (_____) _____

Address (if different from above) _____

INSURANCE INFORMATION - *Please present the receptionist with your insurance card(s)*

Primary Insurance _____ ID # _____ Group # _____

Policy Holder's Name _____ DOB _____ / _____ / _____

Secondary Insurance _____ ID # _____ Group # _____

Policy Holder's Name _____ DOB _____ / _____ / _____

PHARMACY INFORMATION

Preferred Pharmacy _____ Location _____

Prescription/Drug Coverage _____ ID # _____ Group # _____

AUTHORIZATION & RELEASE

I certify the information on this form is accurate and complete to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay the bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I also understand I am responsible for all second opinion and pre-admission review requirements. I acknowledge that Ear, Nose & Throat Surgical Associates have provided me with a copy of their Privacy Practices.

Signature _____ Date _____

If signed by someone other than the patient:

Name _____ Relationship to Patient _____

<u>This form must be signed by the patient or legal guardian PRIOR to receiving any services or items.</u>

This form must be maintained in the patient's electronic health records.