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

Established Patient Information

Last Name _____ First Name _____ MI _____

DOB _____ Last 4 of SSN _____ Marital Status (check one) ☐ S ☐ M ☐ W ☐ D

Address _____ City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Emergency Contact Name _____ Relationship _____ Phone _____

Referring Physician _____ Primary Care Physician _____

Preferred Pharmacy _____ Location _____

INSURANCE INFORMATION - *Please Present Receptionist with Your Insurance Card(s)*

Primary Insurance _____ ID # _____ Group # _____

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

Secondary Insurance _____ ID # _____ Group # _____

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

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 the 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 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.