ENT AND ALLERGY SPECIALISTS

Date

WHO REFERRED YOU TO OUR OFFICE?:

Patient Information

Primary Physician: (First Name) _____ (Last Name)_____M.D. / D.O.

Email Address		Patient Name		SS#
Date of Birth	Sex M F	Marital Status - Single, Married, Widowed, Divorced	Relationship to Guarantor	Previous Name if Changed
Race		Ethnicity	Primary Language	
Address			City, State, Zip	
Home Telephone		Cell or Pager #		
Employer and Address			Work Telephone	
Preferred Pharmacy, Phone Number and Street Address				

Guarantor Information

Responsible or Custodial Parent		Guarantor Name	Social Security #
Date of Birth	Sex M F	Relationship of patient to guarantor	Home Telephone
Guarantor Address			
Guarantor Employer			Work Telephone
Employer Address			

Emergency Contact

Contact Name	Relationship to Patient
Home Telephone	Work Phone

Spouse or Parent

Name	Telephone Number
Address	
Employer	Work Telephone

Insurance

Primary Insurance Company Name			Telephone Number
Address			
Group Number	Policy Number	Effective Date	Relationship to Subscriber
Subscriber's Name			Subscriber's Employer
Secondary Insurance Company Name			Telephone Number
Address			
Group Number	Policy Number	Effective Date	Relationship to Subscriber
Subscriber's Name			Subscriber's Employer

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional service rendered. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I authorize the staff to perform all necessary services needed during diagnosis and treatment. I also authorize the provider to release all information required to process insurance claims.

Signature (if over 18 years of age): Date: