

**EAR, NOSE, THROAT & PLASTIC SURGERY ASSOCIATES, P.C.**

**Patient Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Circle appropriate field: Minor Single Married Divorced Widowed

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Preferred Pharmacy and Location \_\_\_\_\_

**If patient is a minor /or has a legal guardian:**

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

-Employer: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

-Employer: \_\_\_\_\_

**Insurance Information:**

Primary: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Secondary: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Third: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Patient Authorization:**

I certify that the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by my insurance. Additionally I understand that if an account becomes 90 days past due, delinquency at the lesser of the annual rate of 30%, or the maximum allowable rate will be due on delinquent amounts from the date the payment was due. I have also read and understand the Financial Policy and HIPPA Compliancy as presented to me. Upon request I may have a copy of these agreements. My signature also authorizes the release of records for purposes of both payment and coordination of care with other providers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_