

DATE:

EAR NOSE AND THROAT, PC

ACCOUNT:

PHYSICIAN:

PATIENT

NAME:

PATIENT SEX M, F:

ADDRESS:

BIRTH DATE:

CITY, STATE, ZIP:

PATIENT AGE:

TELEPHONE NO.:

REFERRING MD:

SOCIAL SEC.#:

MARITAL STATUS M, S, W, D:

EMPLOYER:

STUDENT E, P, F:

EMPLOYER PHONE: ()

GUARANTOR/RESPONSIBLE PARTY

NAME:

SOCIAL SEC.#:

ADDRESS:

DATE OF BIRTH:

CITY, STATE, ZIP:

INSURANCE

PRIMARY INSURANCE

SECONDARY INSURANCE

NAME:

NAME:

POLICY#:

POLICY#:

GROUP#:

GROUP#:

SUBSCRIBER SSN: _____

SUBSCRIBER SSN: _____

SUBSCRIBER DOB: ___/___/_____

SUBSCRIBER DOB: ___/___/_____

=====
EMERGENCY CONTACT PERSON NOT LIVING WITH YOU: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

IF PATIENT IS MARRIED, SPOUSE'S NAME: _____ WORK #: _____
DOB: _____ SS#: _____

IF PATIENT IS A CHILD, FATHER'S NAME: _____ WORK #: _____
DOB: _____ SS#: _____

MOTHER'S NAME: _____ WORK #: _____
DOB: _____ SS#: _____

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PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: A patient's signature requests that payments be made and authorizes release of medical information necessary to pay the claim. I also request payments of government benefits to myself to the party who accepts assignment. I am financially responsible for non-covered services. I also authorize release of information to my referring doctor.

SIGNATURE _____ DATE _____