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

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 Telephone

Spouse or Parent

Name	Home Telephone

Address

Employer	Work Telephone

Insurance

Primary Ins Company Name **IF WE HAVE YOUR CARD PASS THIS SECTION**	Telephone Number

Address

Group Number	Policy Number	Effective Date	Relationship to Subscriber

Subscriber's Name	Subscriber's Employer

Secondary Ins Com Name **IF WE HAVE YOUR CARD PASS THIS SECTION**	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 (Patient-18 years of age or older, if under age parent or guardian signature)	Date