Ear, Nose and Throat Care, P.C. and Allergy

Patient Information
Patient Name:_______________________________________ Age:_________ Today's Date:_________

Address:____ Date of Birth:___________________

City, State, Zip:____ Male:_________ Female:_________

Marital Status (circle one): Single Married Divorced Widowed

S.S. #:____________________________________ Driver's License #:____________________________

Home Phone #:____________________________ Business Phone #:_____________________________
Cell Phone #:_______________________________

Who referred you to us? ____

Primary Physician ____

Is this visit due to Workman's Compensation? ________ Date of accident:__________________________

Employer
Company Name:____

Address:____

Phone #:____

Responsible Party
Name:____ Date of Birth:__________________

Address:____ Relationship to Patient:___________

City, State, Zip:____ Male:________ Female:__________

Marital Status (circle one): Single Married Divorced Widowed

S.S. #:______________________ Driver's License #:____

Home Phone #:____________________________ Business Phone #:_____________________________
Insurance Coverage (Primary)
Name of Company:___________________________ I.D.#:____________________ Group #:___________

Address (to send claim):____

City, State, Zip:____

Phone # of Insurance Company:____

Subscriber Name:____ Male:_________ Female: _________

S.S. #:________________ Date of Birth:_________________ Relationship to Patient:_________________

Insurance Coverage (Secondary)
Name of Company:___________________________ I.D.#:____________________ Group #:___________

Address (to send claim):____

City, State, Zip:____

Phone # of Insurance Company:____

Subscriber Name:____ Male:_________ Female: _________

S.S. #:________________ Date of Birth:_________________ Relationship to Patient:_________________

I agree that payment for services rendered is my responsibility, and I authorize the release of any medical information necessary to process my claims. I have received the notice of privacy practices.

Signature:____ Date:______________________