

Ear, Nose and Throat Associates of South Florida, P.A.

Patient Information

Please Fill Out Completely

Patient Name: _____				SSN: _____			
Date of Birth: _____		Age: _____		Email Address: _____			
Responsible Party/Guarantor Name: _____							
Patient's Address: _____							
Street		City		State		Zip	
Patient's 2 nd Address: _____				<input type="checkbox"/> Full-time		<input type="checkbox"/> Part-time Resident	
Patient's Phone (Primary) (_____) _____			Patient's Phone (Secondary) (_____) _____			Other/Cell _____	
Marital Status: M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sex: F <input type="checkbox"/> M <input type="checkbox"/> Employer Name: _____							
Emergency Contact: _____			Relationship: _____			Phone# _____	

Referring Physician: _____ Primary Care Physician: _____

Whom may we thank for referring you? _____

Is this visit related to a Work Accident Auto Accident or Other Accident _____

Primary Insurance Information

Primary Insurance Company: _____				Subscriber's Name: _____			
Relationship to Patient: _____		Date of Birth: _____		ID# _____			
Secondary Insurance Company: _____				Subscriber's Name: _____			
Relationship to Patient: _____		Date of Birth: _____		ID# _____			

List below any persons/family members whom you authorize access to your medical records and/or authorize us to leave a detailed message regarding all aspects of your medical chart, health condition, medications and financial history.

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

May we leave a detailed message on voice mail/answering machine? Yes No

All Patients

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Ear, Nose & Throat Associates of South Florida, PA. I further understand that I am financially responsible for any services deemed Non-Covered by my insurance company, and deductibles, co-pays and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician and Ear, Nose & Throat Associates of South Florida to photograph me for medically related documentation purposes. Yes No

Signature: _____ Date: _____

Medicare Patients

I authorize the physicians and/or staff of Ear, Nose & Throat Associates of South Florida, P.A., to release to the Social Security Administration, or its intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles, co-insurance and for any services deemed Non-Covered by Medicare.

Signature: _____ Date: _____