ENT & ALLERGY ASSOCIATES P.S.

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Patient Name _____
Last First M.I.

Address _____ City _____ State _____ Zip Code _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Email _____ SS# _____ Birthdate _____ Age _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Business Address _____ City _____ State _____ Zip Code _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone (_____)_____

Whom may we thank for referring you? _____ Phone (_____)_____

Who is your family physician? _____ Phone (_____)_____

Person to contact in case of emergency _____ Phone (_____)_____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Birthdate _____ Employer _____ Driver's License# _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Work Phone (_____)_____ SS# _____ Birthdate _____

Name of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ ID# _____ Group# _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Insured _____ Relationship to Patient _____

Work Phone (_____)_____ SS# _____ Birthdate _____

Name of Employer _____ City _____ State _____ Zip Code _____

Insurance Company _____ ID# _____ Group# _____

1. **I authorize the release of any medical information.**
2. I understand and agree that I am ultimately responsible for payment.
3. I authorize and request payment of medical benefits directly to my physician.
4. I understand and agree that I am ultimately responsible for payment if my insurance company denies payment for services.
5. I agree that a photocopy of this form maybe used in lieu of the original.

X _____ _____
Signature of patient or parent/guardian if minor Date

104 27th Avenue SE, Puyallup, WA 98374
Phone: 253-770-9000 || Fax: 253-770-9712 || ENTpuyallup.com

PROLIANCE SURGEONS®