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