

DATE _____

PATIENT _____
Last First Middle

ADDRESS _____
Street City State Zip

DATE OF BIRTH ____/____/____ AGE ____ S.S.# _____

HOME PHONE _____ MALE/FEMALE

WORK PHONE _____ SINGLE / MARRIED / WIDOW/OTHER

CELL PHONE _____

EMPLOYER NAME _____

POLICY HOLDER _____ D.O.B. ____/____/____

Mother / Father / Spouse

S.S.# _____ of policy holder

INSURANCE INFORMATION

Please present insurance information to receptionist check if uninsured _____

MEDICAL HISTORY

HEART DISEASE	LUNG PROBLEM	ASTHMA
HYPERTENSION	DIABETES	ULCER
RENAL OR LIVER PROBLEM	BLEEDING DISORDER	NOW PREGNANT

OTHER: _____

SURGERIES _____

MEDICATIONS: _____

DRUG ALLERGIES: _____

REFERRED BY: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE EAR NOSE & THROAT MEDICAL ASSOCIATES TO FURNISH INFORMATION TO INSURANCE CARRIERS AND TO ANY OTHER HEALTHCARE PERSONEL INVOLVED IN MY CARE, CONCERNING MY ILLNESS AND TREATMENT. I CONSENT TO ANY OFFICE EXAM OR PROCEDURE DISCUSSED BY MYSELF AND THE PHYSICIAN DEEMED NECESSARY IN MY TREATMENT. I HEREBY ASSIGN THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE COMPANY. IN THE EVENT IT IS NECESSARY TO REFER UNPAID ACCOUNTS TO A COLLECTION AGENCY, OR ATTORNEY, COSTS OF SUCH WILL BE CHARGED. **I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.**

SIGNATURE _____