

Employee initials: _____

Patient Information

Date _____

Name _____ Marital Status: S M D W Sex: M F

Mailing Address _____
Primary Street City State Zip

Mailing Address _____
Secondary Street City State Zip

Home Phone _____ Birthdate _____ Age _____ SS# _____
mm/dd/yy

Are you employed? Y N Patient Employer _____ Work Phone _____

Spouse or Guardian (if minor) _____ Birthdate _____ SS# _____

Spouse's Employer _____ Work Phone _____

Insurance/ Medicare Information

Do you have Medicare or Medicaid? Y N Medicare HMO Y N
Please take note that we are not Medicaid providers and you will be responsible for any service provided to you by our office.

Primary Insurance _____ Relationship to policy holder _____

Policy Holder _____ Birthdate _____ SS# _____

Secondary insurance _____ Relationship to policy holder _____

Policy Holder _____ Birthdate _____ SS# _____

Physician who requested you consult us: _____ Family Physician: _____

Phone number to reach physician _____

How did you hear about our office? Doctor, Health Fair, Speech, TV, Newspaper, Telephone Book, Family, Friends, Other _____

Insurance Authorization and Assignment

If you are covered by any HMO/PPO and wish to receive services at ENT that have not been authorized, WE ARE AVAILABLE and happy to provide care. You will, however be responsible for payment on the day of your exam or service. Depending on the type of service you require, you may be required to make a deposit or payment agreement for estimated charges prior to being seen.

If you have any questions about authorization, please call your insurance carrier, Member Service Department Or if applicable your HMO/PPO physician.

If you are on a MEDICARE HMO plan please be advised that we are NOT providers. We are happy to treat you but you will be responsible for payment in full at time of your checkout.

I hereby authorize Ear, Nose & Throat Associates of Manatee, PA to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services to myself or dependents. I understand that I am responsible for any amount not covered or authorized by my insurance carrier for all office or surgical charges.

Date _____ Signature _____

Initial	Date	Initial	Date	Initial	Date	Initial	Date
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Any unpaid balance will accrue a 1-% monthly charge after 90 days.