

**Welcome to Our Office**  
Thank you for completing this form.

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
*Last Name First Name Initial*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

In case of emergency who should be notified \_\_\_\_\_  
*Name/Relation to Patient Phone*

**INSURANCE INFORMATION**

Person Responsible for Account \_\_\_\_\_  
*Last Name First Name Initial*

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec# \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

**ADDITIONAL INFORMATION**

By whom were you referred? \_\_\_\_\_

Other Physicians who care for you \_\_\_\_\_

*Circle either yes or no for the following questions:*

May we leave messages on your answering machine?	YES	NO	May we call you at work?	YES	NO
May we release information to your spouse?	YES	NO			

**ASSIGNMENT OF BENEFITS**

I hereby give indefinite authorization for payment of insurance benefits to be made directly to Ear Nose & Throat Specialists, Inc., for services provided. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize the release of all information necessary to secure the payment of benefits. **I understand that failure to provide this office with current insurance information may result in my being responsible for all charges.**

\_\_\_\_\_  
*Signature of Patient, Legal Guardian, or Responsible Party*

Date \_\_\_\_\_