ENT SURGICAL ASSOCIATES

Today's Date _____

PATIENT DEMOGRAPHICS

First Name _____ Middle _____ Last _____

Sex _____ Date of Birth _____ Martial Status _____ Race _____ Ethnicity _____

Address _____ Zip_____ City _____State _____

Email Address _____ (unless minor)

Home Ph _____ Mobile _____ Wk _____ Pref Ph _____

Referring Provider _____ Phone _____

INSURANCE AND SUBSCRIBER INFORMATION

Primary Insurance Name _____

Group #_____ Subscriber ID _____

Subscriber Name _____ Middle _____Last _____DOB _____

Address _____Zip_____City _____ State _____

Home Ph _____ Mobile _____ Wk _____

Email Address _____ Pt Relation to Subscriber _____

Other Insurance _____

Group # _____ Subscriber ID _____

Subscriber Name _____ Middle _____ Last _____

DOB _____ Ph _____ Pt Relation to Subscriber _____

Is patient a Medicare Beneficiary? Yes No Primary or Secondary?

Is patient a Medicaid Beneficiary? Yes No Primary or Secondary?

EMERGENCY CONTACT

Pt Relation to Contact _____

Name _____Middle _____ Last_____

Hm Ph _____ Mobile _____ Wk _____

PHARMACY

Pharmacy Name/Location _____Phone_____

Patient/Responsible Party_____ Relation to Pt _____

Signature Phone _____

As the responsible party, I agree that all charges that are not directly paid by insurance will be my responsibility.