Account No Dr. # FC Diag.

**PATIENT DEMOGRAPHICS** Date

Patient Name Date of Birth

Mailing Address

City State Zip

Daytime Phone Number Home Work Cell Okay to Text? Yes No

Age Sex: M F Marital Status: S M W D Sep SSN

Employer Phone

**GUARDIAN OR SPOUSE INFORMATION**

Name Date of Birth

Mailing Address

City State Zip SSN

Employer Phone

**EMERGENCY CONTACT (outside of household)**

Name Home Phone

Relationship Other Phone

**HOW DID YOU HEAR ABOUT US?**

Patient Primary Care Physician Phone

Other Physician – which one?

**RELEASE OF INFORMATION STRICTLY CONFIDENTIAL**

The ENT & Allergy Center has my permission to release MEDICAL information to the following:

Name Phone Relationship

Name Phone Relationship

The ENT & Allergy Center has my permission to release BILLING information to the following:

Name Phone Relationship

Name Phone Relationship

**INSURANCE INFORMATION**

Insurance Company ID# Group Self-Funded

Subscriber Name DOB SSN

**AUTHORIZATIONS AND ASSIGNMENT - Initial each of the following**

\_\_\_\_\_\_ I have received a copy of the ENT & Allergy Center Compliance Final Patient Privacy rule part 164 HIPAA.

\_\_\_\_\_\_ I understand that it is my responsibility to notify the ENT & Allergy Center in writing of any changes to the above permissions.

\_\_\_\_\_\_ I hereby authorize ENT & Allergy Center to furnish information to Medicare and other insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself and my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature Date