

ADULT PATIENT INFORMATION

PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME

PATIENT'S NAME: _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ **DATE OF BIRTH:** _____ / _____ / _____

ADDRESS: _____ **APT /UNIT:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ - _____

HOME TEL: (____) _____ **ALTERNATE TEL:** (____) _____

SEX (Circle one): Male Female **MARITAL STATUS** (Circle one): Single Married Widowed Divorced

LANGUAGE SPOKEN: English Spanish **Other:** _____ **Email:** _____

PCP/REF PHYSICIAN: _____ **PHONE:**(____) _____ **FAX:**(____) _____

PHARMACY NAME: _____ **PHARMACY PHONE:** (____) _____

EMPLOYER _____ **EMPLOYER TEL** (____) _____

EMPLOYER ADDRESS _____ **OCCUPATION** _____

SPOUSE'S NAME _____ **SPOUSE DOB:** _____ / _____ / _____

SPOUSE'S SOCIAL SECURITY _____ **SPOUSE'S CELL/ALTERNATE #** _____

EMERGENCY CONTACT/RELATIONSHIP _____

PHONE NUMBER: (____) _____ **ALTERNATE NUMBER:** (____) _____

Would you like to designate a personal representative which grants your physician permission to discuss your personal health information (PHI) with your spouse or other family member? **(CIRCLE) YES NO**

NAME OF FAMILY MEMBER _____ **RELATIONSHIP** _____

Do you give permission to our physicians to leave messages on your answering machine/voicemail regarding your Personal Health Information (i.e. test results, etc.)? **(CIRCLE) YES NO**

IF YES, WHAT PHONE NUMBER? _____

HEALTH INSURANCE

*A photocopy of these assignments shall be valid as the original

***PRIMARY INSURANCE:** _____ **POLICY#** _____ **GRP#** _____

INSURED'S NAME _____ **INSURED'S DOB:** _____

INSURED'S SS# _____ **RELATIONSHIP TO PT:** _____

***SECONDARY INSURANCE:** _____ **POLICY#** _____ **GRP#** _____

INSURED'S NAME _____ **INSURED'S DOB:** _____

INSURED'S SS# _____ **RELATIONSHIP TO PT:** _____

NOTICE TO PATIENTS: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

I declare that all information presented at date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize South Florida ENT Associates, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to South Florida ENT Associates, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE: _____

DATE: _____