ENT and Allergy Associates of Florida – Patient Information

Please Fill Out Form Completely

****Race & Ethnicity questions are required to be asked to the patient by the Federal Government****

Salutation: Mr. _____ Mrs. _____ Ms. _____ Dr. _____

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Sex: F _____ M _____ Other _____ **Marital Status:** M _____ S _____ D _____ W _____ Other _____

Please check appropriate response:

Race:** American Indian/Alaska Native _____ Asian _____ Black/African American _____ White _____

Native Hawaiian/Pacific Islander _____ Other Race _____ Decline to answer _____

Ethnicity:** Hispanic or Latino _____ Not Hispanic or Latino: _____ Declined to answer: _____

Religion: _____ **Primary Language:** _____ **Maiden Name:** _____

Responsible Party/Guarantor Name: _____

Patient's Address: _____

Street City State Zip

Patient's 2nd Address: _____

Street City State Zip

_____ Full-time Resident _____ Part-time Resident

Patient's Phone (Primary) _____ **Patient's Phone (Cell)** _____

Email Address:_____

Please check your preference on how to contact you: Home Phone: _____ Cell Phone: _____ Other: _____

Employer Name: _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Whom may we thank for referring you? _____

Referring Physician: _____ **Primary Care Physician:** _____

Is this visit related to a: Work Accident _____ Auto Accident _____ Other Accident _____

Pharmacy Name: _____ **Address:** _____ **Phone #:** _____

Insurance Information

Primary Insurance Company: _____ **Subscriber's Name:** _____

Relationship to Patient: _____ **Date of Birth:** _____ **ID#:** _____ **Group#:** _____

Secondary Insurance Company: _____ **Subscriber's Name:** _____

Relationship to Patient: _____ **Date of Birth:** _____ **ID#:** _____ **Group#:** _____

I consent to medical treatment for myself, my child, or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to ENT and Allergy Associates of Florida. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician and ENT and Allergy Associates of Florida to photograph me for medically related documentation purposes. **Yes** _____ **No** _____

Signature: _____ **Date**: _____