

Patient Name:	DOB:	Sex:	Age :
Address:	City:	St:	Zip:
Marital Status:	SS #:		
Work Phone:	Okay to leave message?		
Cell Phone:	Okay to leave message?		
Home Phone:	Okay to leave message?	e-mail	
Referring Dr:	Ref Dr Phone:		
Address:	City:	St:	Zip:
Primary Care Physician:	PCP Phone:		
Address:	City:	St:	Zip:
Guarantor:	DOB:	SS#	Sex:
Address:	City:	St:	Zip:
Home Phone:	Cell Phone:		
Work Phone:			
Primary Insurance:	Ins Phone:		
Address:	City:	St:	Zip:
Cert No:	Group No:		
Subscriber:	DOB:		
Secondary Insurance:	Ins Phone:		
Address:	City :	St :	Zip:
Cert No:			
Subscriber:	DOB:		
Emergency Contact:	City:	St:	Zip:
Home Phone:	Cell Phone:		
Work Phone:			
Preferred Language:	Race:	Ethnicity:	

**I authorize ENT Physicians & Surgeons, PA to speak to the following on my behalf:**

**I have been offered a copy of the privacy policy.**

**I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs and attorney fees**

**I understand that my signature authorizes payment by the insurance to the provider.**

**I authorize the release of all medical information necessary to pay insurance claims.**

**I authorize the release of all medical information necessary for continuity of patient care.**

**Signature:**

**Date:**

*(Patient or Legal Guardian or POA)*