

# Ear, Nose & Throat Associates of South Florida – Patient Information

## Please Fill Out Form Completely

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

Salutation/Titular: Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Miss \_\_\_ Dr. \_\_\_ Patient Name/Nombre del Paciente: \_\_\_\_\_

Date of Birth/Fecha de Nacimiento: \_\_\_\_\_ Age/Edad: \_\_\_\_\_ Sex/Sexo: F \_\_\_ M \_\_\_

Marital Status/Estado Civil: M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_ Other \_\_\_

Please check appropriate response:

\* \*\*Race: American Indian/Alaska Native \_\_\_ Asian \_\_\_ Black/African American \_\_\_ Declined to answer \_\_\_  
Native Hawaiian/Pacific Islander \_\_\_ Other Race \_\_\_ White \_\_\_

Please check appropriate response:

\*\*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 2<sup>nd</sup> Address: \_\_\_\_\_ Full-time \_\_\_ Part-time Resident

Patient's Phone (Primary) (\_\_\_\_\_) Patient's Phone (Cell) (\_\_\_\_\_) \_\_\_\_\_

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

Email Address: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone# \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Address \_\_\_\_\_ Tele# \_\_\_\_\_

### 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# \_\_\_\_\_

### Check box below or tell us whom we may thank for referring you?

\_\_\_ Radio \_\_\_ Internet \_\_\_ Insurance \_\_\_ Facebook \_\_\_ Zocdoc \_\_\_ Mailer Campaign \_\_\_ Email Campaign

\_\_\_ TV \_\_\_ Website \_\_\_ Health fair Magazine \_\_\_ Friend/Relative (Name) \_\_\_ Dr. \_\_\_\_\_

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 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 Ear, Nose & Throat Associates of South Florida, PA. 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 Ear, Nose & Throat Associates of South Florida to photograph me for medically related documentation purposes. \_\_\_ Yes \_\_\_ No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_