

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 2nd 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 ___ Airport
Friend/Relative (Name) _____ Family Dr. / PCP (Name) _____

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:** _____