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**:____