PATIENT INFORMATION

Patient Last Name	First Name	Date of Birth	Sex M/F

Home Phone	Work Phone	Cell Phone

Social Security Number	E-mail Address

Can you receive text messages on your Cell Phone? Yes / No

Street Address	City	State	Zip Code

Employer Name/Street Address	City	State	Zip Code

Name of Spouse, Parent or Guardian	Date of Birth	Social Security Number

Primary Care Physician/Street Address	City	State	Zip Code

Referring Physician/Street Address	City	State	Zip Code

BILLING AND INSURANCE INFORMATION

Primary Insurance	Subscriber Name	Date of Birth

Policy Number	Group Name/Number

Secondary Insurance	Subscriber Name	Date of Birth

Policy Number	Group Name/Number

Is your illness due to an accident? Yes/ No	If yes, complete carrier information below.
Is your illness work related? Yes/ No	If yes, complete carrier information below.

Compensation Carrier Name/Street Address	City	State	Zip Code

Contact Name	Phone Number	Case/Claim Number

PLEASE READ AND SIGN REVERSE SIDE

CLAIMS AUTHORIZATION

I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTHCARE PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICALLY-RELATED FACILITY TO FURNISH ANY AND ALL RECORDS, MEDICAL HISTORY, AND SERVICES RENDERED OR TREATMENT GIVEN TO ME OR ANY DEPENDENT FOR PURPOSES OF REVIEW, INVESTIGATION OR EVALUATION OF ANY CLAIM SUBMITTED TO ANY INSURER. I ALSO AUTHORIZE ANY INSURER TO DISCLOSE TO A HOSPITAL, OR HEALTH CARE SERVICE PLAN, SELF-INSURER, OR AN INSURER ANY MEDICAL INFORMATION OBTAINED IF SUCH DISCLOSURE IS NECESSARY TO ALLOW THE PROCESSING OF ANY CLAIM.

IF MY COVERAGE IS UNDER A GROUP CONTRACT HELD BY AN EMPLOYER, A TRUST FUND, AN ASSOCIATION, UNION OR SIMILAR ENTITY, THIS AUTHORIZATION ALSO PERMITS DISCLOSURE TO THEM FOR THE PURPOSE OF REVIEW OR AUDIT.

THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY UPON EXECUTION AND SHALL REMAIN IN EFFECT FOR THE DURATION OF THE CLAIM OR TERM OF COVERAGE WITH ANY INSURER INCLUDING REASONABLE TIME THEREAFTER, UNTIL ITS FINAL CONSUMMATION. THIS AUTHORIZATION SHALL BE BINDING UPON ME, MY DEPENDENTS, OUR HEIRS, EXECUTORS AND ADMINISTRATORS.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO REFERRING AND FAMILY PHYSICIANS. I ALLOW FAX TRANSMITTAL IF NECESSARY. I UNDERSTAND AND AUTHORIZE THE EAR, NOSE & THROAT MEDICAL AND SURGICAL GROUP TO CONFIRM APPOINTMENTS VIA ANSWERING MACHINE. I ACKNOWLEDGE FULL FIDUCIARY RESPONSIBILITY FOR SERVICES RENDERED BY THE EAR, NOSE & THROAT MEDICAL AND SURGICAL GROUP.

I VERIFY THE ACCURACY OF THE INFORMATION SUPPLIED ON THIS FORM AND I AUTHORIZE THE RELEASE OF INFORMATION AS PROVIDED ON THIS FORM. I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES INCURRED IN THE COLLECTION OF ANY AMOUNTS NOT PAID AS REQUIRED.

AUTHORIZATION OF PAYMENT

I REQUEST PAYMENT OF THIS CLAIM AND AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OR SUPPLIER FOR THE SERVICES DESCRIBED.

Print Patient Name: ____ **Date of Birth:** ____________________

Responsible Party Signature: ____________________________________ **Date:** ________________________

If signed by someone other than the patient, please state relation to patient:___________________________

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