Orlando Ear, Nose & Throat Associates, P.A.

Head & Neck Surgery, Facial Plastic Surgery, E.N.T. Allergy, Hearing Aids

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PATIENT INFORMATION

Name____Soc. Sec. # ______________
Last Name First Name Initial

Address____City ______________

State______ Zip Code __________ Phone ________________ Email______________________________

Sex ☐ M ☐ F Age________ Birthdate____________________☐Single ☐Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by____Occupation ______________

Business Address____Business Phone ______________

Whom may we thank for referring you?____________________________Phone ______________

In case of emergency, who should be notified?______________Relationship______Phone ______________

PRIMARY INSURANCE

Policy Card Holder ____
Last Name First Name Initial

Relation to Patient____________________Birthdate______________Soc. Sec. # ______________

Address (if different from patient's)________________________________Phone ______________

City ________________________________ State______________Zip ______________

Person Responsible Employed by____________________________Occupation ______________

Business Address________________________________Business Phone______________

Insurance Company ____

Group #________________________________Subscriber # ______________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name________________________Relation to Patient__________Birthdate ______________

Address (if different from patient's)________________________________Phone ______________

City________________________________State______________Zip ______________

Subscriber Employed by____________________________Business Phone_Insurance Company________

____ Soc. Sec. #Group

#________________________________Subscriber # ______________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X ________________________________ ______________________ ______________
Responsible Party Signature Relationship Date