

**PATIENT INFORMATION SHEET (ADULT)**

Patient Name \_\_\_\_\_

**Male or Female**

Social Security # \_\_\_\_\_

Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Referring Doctor Phone: \_\_\_\_\_

\_\_\_\_\_

Family Doctor: \_\_\_\_\_

Home Phone \_\_\_\_\_

Family Doctor Phone: \_\_\_\_\_

Work Phone \_\_\_\_\_

Closest Living Relative (name and #) \_\_\_\_\_

Cell Phone \_\_\_\_\_

\_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_

Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Address of subscriber (if different than above) \_\_\_\_\_

Social Security # of subscriber \_\_\_\_\_ (Required) Date of Birth \_\_\_\_\_

Employer of subscriber \_\_\_\_\_

Employer's address \_\_\_\_\_

\_\_\_\_\_ Employer's Phone \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

Policy or ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Address of subscriber (if different than above) \_\_\_\_\_

Social Security # of subscriber \_\_\_\_\_ (Required) Date of Birth \_\_\_\_\_

Employer of subscriber \_\_\_\_\_

Employer's address \_\_\_\_\_

\_\_\_\_\_ Employer's Phone \_\_\_\_\_

**Insurance Authorization/Assignment**

**I hereby authorize ENT Head & Neck Specialists to release and/or obtain information to/from insurance carriers, other physicians, and/or medical facilities concerning my present illness/treatment and past medical history/treatment. I also hereby assign to the physicians of ENT Head & Neck Specialists all payments for medical services rendered to myself. I understand that I am responsible for any amount not covered by my insurance.**

Signature of patient \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE NOTE: Our office is not responsible for charges incurred if updated insurance information is not provided by the patient.**