

Please print.

PATIENT INFORMATION

NAME _____ SOCIAL SECURITY # _____

MARITAL STATUS: MARRIED, SINGLE, DIVORCED, WIDOWED
(Please Circle)

AGE _____ BIRTH DATE _____ SEX _____

STREET ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP CODE _____

PHONE # () _____ WORK PHONE # () _____ CELL PHONE # () _____

EMAIL ADDRESS: _____

EMPLOYED BY _____ OCCUPATION _____

EMPLOYER'S ADDRESS & CITY _____

NAME OF HUSBAND OR WIFE _____ EMPLOYED BY _____
(Parent, if child)

EMPLOYER'S ADDRESS _____ WORK # _____

EMERGENCY CONTACT _____ PHONE # _____

REFERRING DOCTOR _____ FAMILY DOCTOR _____
Name Relationship

INSURED'S/GUARANTOR NAME _____ INSURED DOB _____

PERSON RESPONSIBLE FOR BILL _____ INSURED SS # _____

PRIMARY INSURANCE

Name and Address of Company: _____

City: _____

State: _____ Zip: _____

Insured's Name: _____

Group #: _____

Policy ID#: _____

Effective Date of Coverage: _____

SECONDARY INSURANCE

Name and Address of Company: _____

City: _____

State: _____ Zip: _____

Insured's Name: _____

Group #: _____

Policy ID#: _____

Effective Date of Coverage: _____

I, THE UNDERSIGNED HEREBY ACKNOWLEDGE THAT IT IS THE POLICY OF THIS OFFICE THAT ALL PAYMENTS BE MADE EACH VISIT AND I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED REGARDLESS OF INSURANCE COVERAGE. I request that payment of authorized insurance benefits be made to me on my behalf to **Otolaryngology Head and Neck Surgery Associates / Farragut ENT Allergy** for services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I will notify you of any changes in the above information.

Please date and sign:

(Date)

Patient's Signature (Parent's if Minor)