ENT and Allergy Associates of 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: Mr.___ Mrs.___ Ms.____Miss____ Dr.____

Patient Name: _____ Date of Birth:_____ Age:_____

Sex: F____ M ____ Marital Status: 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#_____

Whom may we thank for referring you?_____

Referring Physician:_____ Primary Care Physician:_____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

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#_____

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 to any insurance 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 ENT and Allergy Associates of Florida. 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 ENT and Allergy Associates of Florida to photograph me for medically related documentation purposes. Yes_____ No_____

Signature:_____Date:_____