# Ear, Nose & Throat Associates of South 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 Ear, Nose & Throat Associates of South Florida, PA. 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 Ear, Nose & Throat Associates of South Florida to photograph me for medically related documentation purposes. Yes_____ No_____**

**Signature:_____Date:_____**