

# Alliance ENT & Hearing Center, S.C.

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**Referring or Primary Doctor:** \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer or School \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

Person to Notify in Emergency: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

## If Patient is a Child:

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

SS#: \_\_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Primary Ins:** \_\_\_\_\_ Subscriber: \_\_\_\_\_

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

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Second Ins:** \_\_\_\_\_ Subscriber: \_\_\_\_\_

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

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

All professional services rendered are payable by the patient. The patient is responsible for all fees, regardless of insurance coverage. I hereby authorized Alliance ENT & Hearing Center, SC to furnish insurance companies or their representatives information concerning by illness and treatments and I hereby assign Alliance ENT & Hearing Center, SC all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount my insurance does not pay. If I have Medicare, I request the payment of authorized Medicare benefits made on my behalf to Alliance ENT & Hearing Center, SC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the healthcare financing administration and its agents any information needed to determine the benefits payable for related services. This authorization is in effect until I revoke it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_