PATIENT INFORMATION: Please print and fill the form out completely!
Note: Social Security # is needed if the patient requires surgery.

Dr.: ____________________
Date: ____________
Acct: ____________

Social Security # ________________ Name ______________________________
FIRST MI LAST

Address ____
CITY STATE ZIP CODE

Date of Birth ______________ Age ______ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient Sex: ☐ M ☐ F Phone ________________ Cell Phone ____________________

Employed: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student Race: ______________

Employer's Name ____________________________ Work phone ____________________

Do you have a living will? ☐ YES ☐ NO
Is Patient's Condition *Accident* Related: ☐ YES ☐ NO
Is Patient's Condition *Employment* Related: ☐ YES ☐ NO
Auto Accident: ☐ YES ☐ NO

Email ________________________
Date (accident related): __________
Date (employment related): __________
Date/State (auto accident): __________

Ethnicity: ☐ Decline to state ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: ☐ English ☐ Spanish

Were you **referred** to our office? ☐ Yes ☐ No By: ☐ MD ☐ Family/Friend ☐ Other __________

Name of Physician Who Referred You to Our Practice: Dr. ______________________________

Your Primary Care (Family) Physician (or Group your physician practices with):

Dr. ______________________________ Phone ______________________

Name/Relationship of Person(s) with whom we may discuss your medical and account information (if applicable)

1. ______________________________________
2. ______________________________________

Personal Emergency Contact/Name of Nearest Relative NOT Living with You:

Name: ______________________________ Phone ____________________

Address ____

Parent/Guardian if patient is under 18 years old

Father____ Mother____ Other (specify) ______________ Phone ____________________

Name ______________________________ Social Security # ________________
FIRST MI LAST

Address ____
CITY STATE ZIP CODE

Date of Birth: ______________ Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer's Name ______________________________ Work Phone ________________

Please Continue on the Next Page

How did you hear about our practice? ☐ Advertisement ☐ Friend ☐ Physician ☐ Other (specify) ______________

If you have medical insurance please complete the following:

Primary Insurance Co. ______________________________

Policy Holder/ Name of Person Insurance is in

____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Phone ______________________________

Insured's Social Security # ______________________________

Date of Birth ______________ Sex: ☐ M ☐ F

Member ID or Identification # ______________________________

Emp ID or Group # ______________________________

Insurance Address ______________________________

Effective Date

Secondary Insurance Co. ______________________________

Policy Holder/ Name of Person Insurance is in

____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Phone ______________________________

Insured's Social Security # ______________________________

Date of Birth ______________ Sex: ☐ M ☐ F

Identification # ______________________________

Group # ______________________________

Insurance Address ______________________________

Effective Date

Employer information is required by some insurance companies. Please complete.

Employer's Name ______________________________

Employer's Phone ______________________________

Employer's Name ______________________________

Employer's Phone ______________________________

"I request that payment of authorized insurance benefits be made either to me or on my behalf to the name of provider of service."

"I request that payment of authorized Medicare, Medigap and other insurance benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service."

***Patients scheduled for Speech Therapy, a Transnasal esophagoscopy or Videostrobe* must cancel their appointment 48 hours in advance.** Failure to do so will result in a $25 personal charge. When a patient fails to keep a scheduled appointment, it prevents someone else who may need that appointment from receiving medical care, ultimately leading to a rise in medical health costs for everyone.

☐ I acknowledge that I am aware that Metropolitan ENT Associates observes the HIPAA Privacy Policy.

SIGNATURE______________________________ Date ______________________

PAYMENT IS DUE WHEN SERVICE IS RENDERED.

☐ **Please check here if we have your permission to leave a message on your answering machine or voice mail.**