

# Ear, Nose and Throat Specialists of Middletown, Inc.

## PATIENT INFORMATION SHEET

Please print legibly

### PATIENT INFORMATION

Name: (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F Marital Status:  S  M  W  D

Address: (Street) \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Driver License or State I.D.#: \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Social Security#: \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Friend or Relative Not Living with You: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Work #: ( \_\_\_\_\_ ) \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer's Address: (Street) \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

### INSURANCE SUBSCRIBER (If Not Patient)

Name:(First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Relationship \_\_\_\_\_

Address: (Street) \_\_\_\_\_

City, State, ZIP \_\_\_\_\_ Driver License or State I.D.#: \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_ Social Security#: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Work #: ( \_\_\_\_\_ ) \_\_\_\_\_ Employer's Name \_\_\_\_\_

Employer's Address: (Street) \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

### PARENT INFORMATION (IF Minor Child)

#### FATHER:

Name: \_\_\_\_\_

Address: (Street) \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Social Security#: \_\_\_\_\_

Date of Birth \_\_\_\_\_

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

Employer's Address: (Street) \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Employer Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

#### MOTHER:

Name: \_\_\_\_\_

Address: (Street) \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Social Security#: \_\_\_\_\_

Date of Birth \_\_\_\_\_

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

Employer's Address: (Street) \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Employer Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Insurance: (circle one) Primary Secondary

Insurance: (circle one) Primary Secondary

## CONSENT FOR SERVICES

I hereby assign, transfer, and set over to Ear, Nose and Throat Specialists of Middletown, Inc. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: \_\_\_\_\_  
(Parent or Guardian, if minor)

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

## STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I certify that the information given by me in applying for payment under Title XVI I I of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service.

I request that payment under the medical insurance program be made to the above named physician(s).

Patient's Signature: \_\_\_\_\_

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