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 #: (_____)_____

Insurance: (circle one) Primary Secondary

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

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: _____ Date: _____
(Parent or Guardian, if minor)

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: _____