INSURANCE FORM

E·N·T of ATHENS

Date _____ Referred by _____

Name _____ Sex ❑ M ❑ F Primary Care (PCP) _____

Date of Birth _____ Age _____ Soc. Sec. # _____

Note: Children under age 18 must be accompanied by a parent.

Home Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____ Marital Status _____

Person Responsible for Payment _____ Relationship _____

Employer _____ How Long Employed _____ Business Phone _____

Employer's Address _____

Spouse's Name or Other Parent _____

Employer _____ How Long Employed _____ Business Phone _____

Employer's Address _____

Emergency Contact _____ Phone _____ Relationship _____

Are any family members current patients? ❑ No ❑ Yes Who? _____

INSURANCE INFORMATION

Note: Please present all insurance cards at the front window.

Name of Policy Holder _____ Company _____

Policy Holder Soc. Sec. # _____ Policy Holder Date of Birth _____

I hereby authorize ENT of Athens to obtain medical records and pharmacy records from other sources as may be needed in the treatment of this patient.

I hereby authorize ENT of Athens to release information concerning this patient's treatment to other physicians involved in the care and treatment of this patient.

I hereby authorize ENT of Athens to release information to the insurance company as needed to file for charges incurred by this patient.

A copy of this authorization shall be as valid as the original.

I hereby authorize ENT of Athens to provide all necessary treatment for this patient.

Signed _____ Date _____

I hereby authorize the release of my medical information to the following: _____

_____

This authorization will remain effective until ENT of Athens receive a written notice revoking authorization.