DEMOGRAPHIC / INSURANCE FORM

PATIENT DEMOGRAPHIC INFORMATION

Children under age 18 must be accompanied by a parent or guardian.

TODAY'S DATE: ______________________

PATIENT'S NAME: ______________________

LAST NAME | FIRST NAME | MIDDLE INITIAL

HOME ADDRESS: ______________________

CITY / STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE

❑ CHILD ❑ SINGLE ❑ MARRIED
❑ DIVORCED ❑ WIDOWED

SOCIAL SECURITY # | DATE OF BIRTH | AGE | GENDER | MARITAL STATUS

EMAIL ADDRESS | PHARMACY (INCLUDE PHONE # AND ADDRESS)

Are any family members current patients?

PRIMARY CARE or REFERRING PHYSICIAN NAME

❑ YES ❑ NO Who?

INSURANCE INFORMATION

PRIMARY: Name of Insurance ______________________

NAME OF INSURED | INSURED EMPLOYER | INSURED'S DOB | INSURED'S SOCIAL SECURITY #

SECONDARY: Name of Insurance ______________________

NAME OF INSURED | INSURED EMPLOYER | INSURED'S DOB | INSURED'S SOCIAL SECURITY #

COMPLETE ONLY IF PATIENT IS A MINOR

MOTHER'S NAME:	FATHER'S NAME:
MOTHER'S DOB:	FATHER'S DOB:
MOTHER'S ADDRESS:	FATHER'S ADDRESS:
MOTHER'S PHONE #:	FATHER'S PHONE #:
SOCIAL SECURITY #:	SOCIAL SECURITY #:

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 provide all necessary treatment for this patient. I hereby authorize ENT of Athens to release any medical information to my insurance company or physicians involved in the care and treatment of this patient. I understand that I am responsible for ALL charges. I authorize ENT of Athens to file my insurance on my behalf. In the event that my insurance company does not pay for any services rendered, I am responsible for those charges. I understand that it's my responsibility to notify the office of any change, such as address, phone numbers, family doctor, and insurance plans. I understand that if my insurance requires a referral, then it's up to me to make sure this is done. I also understand that if I change insurance companies or family physician, then my current referral is VOIDED. I must contact my current family doctor to get a new referral. I understand if I fail to notify the office of any changes, that I will be held accountable for those charges.

SIGNATURE | RELATIONSHIP TO PATIENT (IF NOT PATIENT SIGNATURE)