Patient Acct #: _____

EAR, NOSE & THROAT SPECIALISTS, LLC

We ask that payment be made at the time of each office visit. We accept: MasterCard, Visa, Discover, Cash or Check

PATIENT

Patient's Name: Last	First *(legal)*:	Middle Initial:	
Address:			
City:	State:	Zip:	
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
SSN#:	Date of Birth:	Age:	
Home Phone #	Work #	Ext #	Cell #
Employer:	Occupation:		
Email Address:			

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unreported/Refused to Report

Race
☐ White ☐ American Indian or Alaskan Native
☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Pacific Islander
☐ More than one race ☐ Unreported/Refused to Report

How would you like to receive appointment reminders?
☐ Postal ☐ Phone ☐ Web Message

Preferred Language:
_____

Pharmacy Name: Street/City: Phone:

Mail Order Pharmacy Name: Phone:

Family Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Emergency Contact Name: Phone: ☐ Home ☐ Work ☐ Cell

**** Please present your insurance card and picture I.D. to the receptionist ****

INSURANCE

Primary Insurance:_____ Policy/ID # _____ Group# _____

Subscriber's Name: _____ DOB_____ SSN _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

Secondary Insurance _____ Policy/ID # _____ Group# _____

Subscriber's Name: _____ DOB:_____ SSN: _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Guardian ☐ Other

FOR ALL PATIENTS WHO ARE UNDER 18 YEARS OF AGE

FINANCE

Father's Name
Name-Last: First: (legal) Middle Initial:

Address: (if different than patient)

SSN#:	DOB:	Home#
Employer:	Work #	Cell#

FINANCE

Mother's Name
Name-Last: First: (legal) Middle Initial:

Address: (if different than patient)

SSN#:	DOB:	Home#
Employer:	Work #	Cell#

1. I authorize Arthur Torsiglieri, MD, Donald Cote, MD and/or Adam French, MD to release to my insurance carriers any information requested concerning my examination or treatment, and I understand that I am responsible for any charges not covered by my insurance. I hereby authorize payment directly to Arthur Torsiglieri, MD, Donald Cote, MD and/or Adam French, MD for surgical and medical benefits payable for the services performed.

2) I authorize the administration of any anesthetics and analgesics (eardrops and medication) that the doctor / PA advises.

3) My signature below indicates that I am aware of ENT Specialists, LLC's Privacy Policy and it's availability for my review.

4) I authorize ENT Specialists staff to contact me AND/OR leave a message at: home ☐ work ☐ or with _____

_____ _____ _____

SIGNATURE OF PATIENT OR GUARDIAN PRINTED NAME OF GUARDIAN DATE