# Ear, Nose & Throat Associates of South Florida – Patient Information

Please Fill Out Completely

Patient Name: _____ SSN: _____

Date of Birth: _____ Age: _____ Email Address: _____

Responsible Party/Guarantor Name: _____

Patient's Address: _____
Street City, State Zip

Patient's 2nd Address: _____ ____Full-time ____Part-time Resident

Patient's Phone (Primary) (____)_____ Patient's Phone (Secondary) (____)_____ Other/Cell

Marital Status: M ____ S____ D ____ W_____ Sex: F____ M ____ Employer Name: _____

Emergency Contact: _____ Relationship: _____ Phone# _____

Referring Physician: _____ Primary Care Physician: _____

Whom may we thank for referring you? _____

Is this visit related to a Work Accident_____ Auto Accident _____ or Other Accident _____

**Primary Insurance Information**

Primary Insurance Company: _____ Subscriber's Name: _____

Relationship to Patient: _____ Date of Birth: _____ ID# _____

Secondary Insurance Company: _____ Subscriber's Name: _____

Relationship to Patient: _____ Date of Birth: _____ ID# _____

List below any persons/family member whom you authorize access to your medical records and/or authorize us to leave a detailed message regarding all aspects of your medical chart, health condition, medications & financial history.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

May we leave a detailed message on voice mail/answering machine? _____Yes _____No

## All Patients

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Ear, Nose & Throat Associates of South Florida, PA. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician and Ear, Nose & Throat Associates of South Florida to photograph me for medically related documentation purposes. Yes_____ No_____

Signature: _____ Date: _____

## Medicare Patients

I authorize the physicians and/or staff of Ear, Nose & Throat Associates of South Florida, P.A., to release to the Social Security Administration, or it's intermediary carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles, co-insurance and for any services deemed Non Covered by Medicare.

ARE YOU HIV POSITIVE? ❑ YES ❑ NO

ARE YOU OR HAVE YOU BEEN UNDER TREATMENT FOR ANY OF THE FOLLOWING (CIRCLE ALL WHICH APPLY):

| | | | |
|---|---|---|---|
| ASTHMA | CYSTIC FIBROSIS | ULCER/REFLUX | AIDS |
| AUTO IMMUNE DISEASE | EMPHYSEMA | COLITIS/BOWEL DISEASE | BLEEDING DISORDER |
| ALLERGY | IMMUNO DEFICIENCY | ARTHRITIS | HEPATITIS |
| THYROID DISEASE | HYPERTENSION | MENINGITIS | DEPRESSION |
| DIABETES | MIGRAINES | CANCER | STROKE |
| EAR DISEASE | HEART DISEASE | SINUSITIS | SEIZURES |

LIST ANY FAMILY MEDICAL HISTORY OF THE ABOVE WHICH MAY BE CONTRIBUTORY TO YOUR HEALTH:

_____

_____

_____

ARE YOU TAKING PRESCRIPTION MEDICATIONS INCLUDING ASPIRIN? ❑ YES ❑ NO

IF YES, WHAT ARE THEY? _____

_____

LIST ANY MEDICINE YOU ARE ALLERGIC TO: _____

DO YOU SMOKE? ❑ YES ❑ NO

HEIGHT _____ WEIGHT _____

LIST ANY TYPE OF EAR, NOSE, THROAT OR NECK SURGERY YOU HAVE HAD:

_____

_____

_____

LIST ANY COSMETIC SURGERY / TREATMENT / PROCEDURE OF THE FACE, NOSE, NECK OR EYES YOU HAVE HAD:

_____

_____

_____

USE THIS SPACE TO DESCRIBE YOUR COMPLAINT:

_____

_____

_____

HOW DID YOU LEARN ABOUT THE DOCTOR? _____

WHO MAY WE THANK FOR THIS REFERRAL? _____

COMMENTS:

_____

_____

_____