# PATIENT INFORMATION

**Photo I.D. and Insurance card(s) required at every patient appointment to verify identity - per FTC guidelines.**
Thank you for choosing ENT Surgical Associates! In order to serve you properly, please complete both sides of this form. Please print clearly. ALL information is kept confidential. If the information you provide is not correct - we cannot process your claim through your insurance company. **ALL copays are due at time of service.**

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ American Indian ☐ Alaskan Native
☐ Multi-racial ☐ Hawiian ☐ Latino

Status: ☐ Single ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: _____ Zip Code: _____

Patient Employer: _____ Work Phone: _____ ext. _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Nearest Relative (not living with patient): _____ Phone: _____

Person to contact in case of an Emergency: _____ Phone: _____

Emergency Contact Relation to patient: _____ Work/Cell Phone: _____

**Does the patient have an Advance Directive? YES or NO**

Referring Physician or Family Physician: _____

e-mail address: _____

## RESPONSIBLE PARTY INFORMATION

Name of Responsible Party: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____
(write same - if address is the same as the patient)

Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____

SSN: _____ Date of Birth: _____ DL State/Number: _____

Employer: _____ Address: _____

## PRIMARY INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Copay Amount: $_____ Effective Date of Policy: _____ Expiration Date of Policy: _____

**Does the patient have a Secondary Insurance to be filed?** ☐ **YES** ☐ **NO**
If the answer is **YES** - Please complete the back of this form with the Secondary Insurance information.
If the answer is **NO** - Signature required on the back of completed form

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## SECONDARY INSURANCE INFORMATION

**(ONLY IF APPLICABLE FOR PATIENT)**

Name of Insured: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____

Address of Employer: _____ City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Copay Amount: $_____ Effective Date of Policy: _____ Expiration Date of Policy: _____

I authorize release of any information concerning my (or my dependent's) health care, advise and treatment providing for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits payable to the insured party to be directly to ENT Surgical Associates of Central Georgia, PC and/or ENT Surgical Center of Central Georgia, Inc. I understand that I am financially responsible for any charges not covered by my insurance, due in full upon receipt of notice. ALL information used for any purpose wil be within the guidelines stated in our patient privacy policy according to HIPPA Law.

ENT Surgical Associates and ENT Surgical Center are separate facilities and are billed seperately. All claims are filed to the insurance company as a courtesy to our patients - but if the claim is denied the patient or the responsible party will be held responsible for payment(s). Any out-of-network claims for the ASC that have been paid to the insured party must be remitted immediately or the patient/insured party will be responsible for the account in full upon receipt. Signing below states you verify all information to be complete and accurate and understand our policy for insurance processing and payment(s) to our practices. The Insurance company is responsible for the patient's policy and it is a contract between the Policy holder and Insurance Company.

_____ _____

**Signature of Patient (or Parent/Guardian if patient is a minor)** **Date**

Appointment confirmations and mail-outs provided by email... what's your email address? _____

**PLEASE TAKE AN ADDITIONAL MINUTE TO TELL US HOW YOU HEARD ABOUT OUR OFFICE...**

**Select from the following list - mark/complete any that apply. Thank you for your time and help!**

- ☐ FAMILY
- ☐ FRIEND _____
- ☐ MED-STOP
- ☐ EMERGENCY ROOM
- ☐ INTERNET - Search Engine _____
- ☐ ENT WEBSITE (www.entsurgical.info)
- ☐ REFERRAL FROM DR. _____
- ☐ EMPLOYEE AT ENT SURGICAL ASSOCIATES/CENTER
- ☐ YELLOW-PAGES ADVERTISEMENT
- ☐ OTHER: _____

**COMPLETE ALL INFORMATION ON THIS FORM AND RETURN IT TO THE RECEPTIONIST.**

**INSURANCE CARD AND PICTURE I.D. ALSO REQUIRED-**
**WE CANNOT FILE A CLAIM TO THE INSURANCE WITHOUT THE INSURANCE CARD.**
**THANK YOU.**

FORM MUST BE COMPLETED AND SIGNED OR INSURANCE CAN NOT BE PROCESSED.
PAYMENT(S) REQUIRED IN FULL BEFORE APPOINTMENT WITH THE PROVIDER.