Welcome to: Ashland ENT, Allergy & Hearing Aid Center

To better serve you, please complete as accurate as possible.

Appointment Date:

First Name:	MI:	Last Name:
Date of Birth:	SSN:	Sex: F M
Address:		
Zip Code:	City:	State:
Home Phone:	Work:	Cell:
Marital Status:	Email:	
Race: White Black or African American Asian American Indian or Alaskan Native Other		
Primary Care Physician's Name: Referring Physician's Name:		PCP Phone #: Referring Phone #:
In the event of an Emergency please contact:	Name:	
Relationship:	Phone:	

Responsible Financial Party: If Other Than Yourself (Minors)

First Name:	MI:	Last Name:
Address:		Phone:
SSN:	DOB:	Gender: M F

How did you hear about us? _____

Please present your insurance card(s) to the receptionist. Please provide which insurance is primary/secondary.

Primary Ins:	
Subscriber Name:	Subscriber SSN:
Subscriber DOB:	Relation to Patient:
Secondary Ins:	
Subscriber Name:	Subscriber SSN:
Subscriber DOB:	Relation to Patient:

*Patients with **Medicare**: Are you or your spouse actively working and have health insurance coverage: ↑Yes ↑No*
Please specify: _____
Insurance information: Effective:_____ Copay:_____

Patient's or Authorized Person's Signature:

I the undersigned give my authorization to treat and assign directly to Ashland ENT, Allergy & Hearing Aid Center all medical benefits, if any, otherwise payable to me for services rendered. ***I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Patient/Guardian Signature:_____ Date: _____