Provident E.N.T.

Date:_____ PENT#_____

PLEASE PRINT

Patients Name:_____Male____Female:___
(Last) (First) (Middle) (Preferred name)

MailingAddress:_____City:_____
(Street name and Number)

State:_____ Zip Code :_____Home Phone:_____ Email address:_____

Street address (if different from above):_____

Age:_____ Date of Birth:_____SS#:_____Marital Status: M S D W

Employment: _____Work Phone:_____ Cell Phone:_____

Name of spouse:_____SS#:_____Birthdate:_____

Spouse's Employment_____ Phone: _____Ext:_____

IF PATIENT IS A CHILD/STUDENT:

Mother's Name:_____SS#:_____Birthdate:_____

Mothers Employment:_____ Bus. Phone:_____ Cell Phone:_____

Father's Name:_____ SS#:_____ Birthdate: _____

Fathers Employment: _____Bus. Phone:_____ Cell phone:_____

School Currently Attending:_____ City & State:_____

OTHER INFORMATION:

Family Physician:_____ Phone #:_____ City & State:_____

Who referred you to our office? _____

Reason you are being seen to day? _____

Emergency contact (someone outside of your current residence): Name:_____

Relationship:_____ Phone Number:_____

Pharmacy you currently use:_____ City:_____ Phone #:_____

INSURANCE INFORMATION: (if you have you card, we will scan it in, no need to complete this section)

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

Secondary Insurance: _____ Insured:_____ ID/Group#:_____

I authorize Provident E.N.T. to furnish my insurance company medical and any other information necessary to process insurance claims. I hereby assign payment of insurance benefits on services rendered. I understand that I am responsible for any health insurance co-payments, co-insurance, deductibles, non-covered services, or remaining charges. This authorization also gives my consent for treatment.

I am aware that if my account goes over 60 days with no payment, a collection process may begin. In the event an outside collection agency becomes necessary, my account may be charged a collection fee.

Signature:_____Date:_____
(Patient/Parent/Legal Representative)