ENT ASSOCIATES OF ALABAMA, P.A

Patient Information Record

If patient is 18 and under, parent or legal guardian must complete this section.

Father's Name: _____ Social Security #: _____Date of Birth: _____

Home Address: _____

Street City State Zip

Employer: _____ Work Phone/Cell: _____

Mother's Name:_____ Social Security #: _____Date of Birth: _____

Home Address: _____

Street City State Zip

Employer: _____ Work Phone/Cell: _____

Patient's Name: _____ Referred by Dr._____

Mailing Address: _____ Phone: ( )_____

PO Box or Street # City State Zip

Physical Address: (if different) _____

Employer: _____ Business Phone/Cell: _____

Occupation: _____ Business Address: _____

Sex: _____ Race: □ Asian □ Caucasian □ Black/African American □ Hispanic □ Multi-Racial

Marital Status: □ Single □ Married

How did you decide to come to our practice? Friend __ Yellow Page__ Ref Dr. ___ Ad___

Social Security #:_____ Date of Birth: _____ Age: _____

Spouse: _____ Employer: _____ Work Phone/Cell:_____

In case of emergency, contact (nearest friend or relative not in same household) _____ Phone:_____

Primary insurance company: _____

Policy/Contract #: _____ Group #: _____

Insured's Name: _____ Date of Birth: _____

Secondary insurance company: _____

Policy/Contract #: _____ Group #: _____

Insured's Name: _____ Date of Birth: _____

Problems you will see the doctor for today: _____

Date problem first occurred: _____ Is problem related to work injury or motor vehicle accident? ____

Is any other members of you family a patient of our office? _____ If yes, Name: _____

Patient Agreement, Assignment of Benefits, Release of Records, and Authorization of Treatment

I, the undersigned, promise to pay, in full, to ENT Associates of Alabama, P.A. for any and all charges in consideration of work done and materials furnished immediately upon such charges being incurred. Upon default, I agree to pay any rebilling charges, interest charges, reasonable legal fees, all costs associated with the collection of this note, I further understand that if payment becomes 90 days past due, I will also be responsible for paying a delinquency charge at the maximum allowable rate from the date the payment was due.

I hereby authorize assignment of benefits to ENT Associates of Alabama, P.A for any medical services rendered by them. I also authorize release of my medical records and any documentation necessary to obtain reimbursement for services rendered.

In the event that I am referred to another provider, I authorize ENT Associates of Alabama, P.A to forward my medical record as it relates to such referral to the provider. Additionally, upon my verbal request for a copy of my record and repayment for such copies, this shall serve as sufficient authorization. A copy shall be as valid as the original.

Signature of Patient (Parent or Guarantor): _____ Date: _____