

Upper Cape Ear, Nose & Throat

Patient Name _____

Date of Birth ____ - ____ - ____ Soc. Sec # ____ - ____ - ____

Mailing Address _____

Phone: Home (____) ____ - ____, Work (____) ____ - ____, Cell (____) ____ - ____

Email Address _____

Parent/Guardian (if applicable) : _____

Emergency Contact Name _____ Phone _____

Primary Physician: _____

Pharmacy: _____

Primary Insurance _____ 2nd Ins. _____ 3rd Ins. _____

Is the Patient the Policy Holder? Yes ___ No ___

If No, Who is the Policy Holder? _____

Address (if other than patient) _____

Date of Birth _____ SSN# _____ Relationship to Patient _____

I, the undersigned, understand that I am responsible for all insurance co-payments, deductibles, and any other charges not covered by my/our insurance policy, including any services rendered without an insurance referral from my Primary Care Doctor.

Patient's Signature (Parent/Guardian, if a minor)

Date

I also authorize payment of medical benefits to Upper Cape Ear, Nose & Throat for any services furnished to me by the physician(s), and authorize Upper Cape Ear, Nose & Throat to release to my insurance company information concerning health care, including information about alcohol or drug use, or HIV status, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient's Signature (Parent/Guardian, if a minor)

Date

*I have been given the Privacy Policy for Upper Cape Ear Nose & Throat, and any concerns have been addressed with me.
I give permission to release my medical information to the following people:*

Patient's Signature (Parent/Guardian, if a minor)

Date