Connecticut Ear, Nose & Throat Associates

ACCOUNT NO. _____

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

S.S.N.:_____ **Birth Date:**_____ **Age:**_____

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

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Email Address:_____

Pharmacy Name:_____ **Phone:**_____ **Location:**_____

Sex: ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referring Doctor Name:_____

Emergency Contact:_____ **Address:** _____

Relationship:_____ **Phone:**_____ **Phone:**_____

RACE:
☐ WHITE / CAUCASIAN ☐ ASIAN
☐ BLACK / AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKA NATIVE
☐ HISPANIC / LATINO ☐ OTHER _____
☐ PATIENT DECLINED INFORMATION

ETHNICITY:
☐ HISPANIC / LATINO
☐ NOT HISPANIC / LATINO

LANGUAGE:
☐ ENGLISH ☐ FRENCH
☐ SPANISH ☐ RUSSIAN
☐ POLISH ☐ TURKISH
☐ OTHER_____

Primary Insurance Information

Insurance Name:_____
Primary Cardholder:_____
Relationship:_____
Birth Date:_____ **SSN:**_____
Identification Number:_____
Group Policy Number:_____

Primary Care Doctor

Name:_____
Address:_____
Phone:_____

Secondary Insurance Information

Insurance Name:_____
Primary Cardholder:_____
Relationship:_____
Birth Date:_____ **SSN:**_____
Identification Number:_____
Group Policy Number:_____

Employer Information (of Subscriber)

Employer:_____
Address:_____
City:_____
State:_____
Phone:_____

Workers Compensation: ☐ Yes ☐ No

If yes, please indicate the date and how you were injured on the job:_____

_____

Have you reported this injury to your employer? ☐ Yes ☐ No

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Connecticut Ear, Nose & Throat Associates, P.C. all surgical and/or medical benefits, if any. (This includes, but is not limited to, Medicare, Commercial Carriers and any applicable Managed Health Care organizations). I understand that I am financially responsible for charges not covered by this assignment and agree to bear any reasonable cost of collection including court costs and attorney's fees should this be required.

_____ _____

Date **Signed (Patient or Parent if Minor)**