Ear, Nose & Throat Associates of Corpus Christi

PATIENT INFORMATION (PLEASE PRINT)
To Be Completed by Patient at Time of Appointment.

Last Name _____

First Name _____

Middle Name _____

Address _____

Mailing Address _____

City _____ **State** _____**Zip**_____

Home Phone _____ **Cell**_____

Work Phone _____**Ext**_____

Date of Birth _____

Social Security # _____

Marital Status _____

Sex: **Male** **Female** **Transgender**

PLEASE CIRCLE:

Prefer Messages: **Morning**

Afternoon

Evening

RACE: Asian-Native Hawaiian-White-Hispanic-Other Black or African American-Refuse to Answer

ETHNICITY: **Hispanic or Latino**

Not Hispanic or Latino

Refuse To Answer

Employer Name _____

Employer Address _____

_____

Primary Care Physician _____

Referring Doctor _____

RESPONSIBLE PARTY
(IF PATIENT A MINOR)

Name _____

Date of Birth _____

Address _____

City _____**State**_____ **Zip** _____

Phone # _____

Social Security # _____

Relation to Patient _____

POLICY HOLDER
(IF DIFFERENT FROM PATIENT)

Name _____

Address _____

City _____ **State**_____ **Zip**_____

Social Security # _____

Phone # _____

Employer _____

Relation to Patient _____

Date of Birth _____

EMERGENCY CONTACT INFORMATION

Name _____

Address _____

City _____ **State**_____ **Zip**_____

Relation _____ **HIPAA Y N**

Phone # _____

PHARMACY _____

EMAIL ADDRESS _____ __

SEE BACK OF FORM

1. **INSURANCE COMPANY:** _____ Phone #: ( ) _____

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

   Group #: _____ **Policy #:** _____ **Member ID #:** _____

2. **INSURANCE COMPANY:** _____ **Phone #: ( )** _____

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

   Group #: _____ **Policy #:** _____ **Member ID #:** _____

Assignment of Insurance Benefits: In the event that the undersigned is entitled to benefits of any type as part of any insurance policy covering patient or any other party liable to patient, said benefits are hereby assigned to ENTA for application to patient's bill. The undersigned shall be responsible for any and all charges not covered by such an insurance policy or policies.

Financial Agreement: The undersigned agrees, whether signing as a patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay any balance outstanding after reassignment and payment of insurance benefits. Should the account be referred to an outside agency for collection, the undersigned shall pay reasonable collection and/or attorney expenses. In the event of cash payment for services or if patient is to self-pay, payment in full is due at the time services are rendered.

Release of Information: ENTA may disclose all or any part of patient's record to any individual or corporation which is or may be liable under a contract with ENTA, to the patient or to a family member or employer of the patient for all or part of ENTA's charges, including but not limited to: hospital or medical service companies, insurance companies, worker's compensation carriers, welfare or public assistance funds, private foundations or charitable organizations, or the patient's or guarantor's employer/s. ENTA shall comply with Federal Privacy Act and HIPAA and shall not disclose patient information to parties not authorized to receive such information under these regulations.

I attest that the information I have provided to ENTA is true and accurate and I agree to the terms outlined above.

_____

Patient or Guarantor Signature (Guardian if patient under 18 years of age) **DATE**