CONNECTICUT EAR, NOSE & THROAT, SINUS & ALLERGY SPECIALISTS, P.C.

Email address:		Today's Date:

PATIENT INFORMATION

Last Name:	First Name:	MI:	DOB:
Address:	City, State, Zip:		
Race: Language: Ethnicity:	[ ] Male [ ] Female	[ ] Married [ ] Single [ ] Divorced [ ] Widowed	SS#	Home Phone #:
Patient's Employer:	Occupation:	Work Phone #:	Cell Phone #:
Employer Address:	City:	State, Zip:	
Primary Care Physician:	Primary Care Physician's Phone #:		
Emergency Contact :	Relationship to Patient:	Contact Phone #:	
Whom May We Thank for the Referral?	If referred by another doctor, please list their address and phone:		

Are you here for: [ ] Work Related Injury [ ] MVA [ ] Disability [ ] Other: _____

SPOUSE / GUARDIAN INFORMATION

Spouse/Guardian Last Name:	First Name:	Relationship:	DOB:	SS#:
Address (If Different from Patient):	City, State, Zip:	Phone #:		
Employer:	Occupation:	Employer Address:	City:	State:

PRIMARY INSURANCE

Insurance Carrier:	Insurance ID Number:	Group Number:

Co-Pay:	Effective Date:	Referral Required? [ ] Yes [ ] No	Referral Number:	Referral Effective Dates and # of Visits:

Policy Holder:	DOB:	SS#:	Employer:

SECONDARY INSURANCE

Insurance Carrier:	Insurance ID Number:	Group Number:

Co-Pay:	Effective Date:	Referral Required? [ ] Yes [ ] No	Referral Number:	Referral Effective Dates and # of Visits:

Policy Holder:	DOB:	SS#:	Employer:

TERTIARY INSURANCE

Insurance Carrier:	Insurance ID Number:	Group Number:

Co-Pay:	Effective Date:	Referral Required? [ ] Yes [ ] No	Referral Number:	Referral Effective Dates and # of Visits:

Policy Holder:	DOB:	SS#:	Employer:
[redacted]			

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN FOR MEDICAL SERVICES PROVIDED. I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. IN THE EVENT THAT MY INSURANCE COMPANY DENIES PAYMENT OF A CLAIM IN WHOLE OR PART, **I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL. COPAY IS DUE AT THE TIME OF SERVICE.**

PRINT PATIENT/GUARDIAN NAME: _____ DATE: _____

PATIENT/GUARDIAN SIGNATURE: _____ RELATIONSHIP: _____