

PATIENT INFORMATION SHEET

PATIENT NAME: _____ REFERRED BY: _____

SS#: _____ DATE OF BIRTH: _____ AGE _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME () _____ WORK () _____ CELL () _____

E-MAIL ADDRESS (optional) _____ MARITAL STATUS: (circle) S M W D

EMPLOYER: _____ OCCUPATION: _____

SPOUSE NAME: _____ SPOUSE'S EMPLOYER: _____

EMERGENCY CONTACT: _____ TEL# _____ RELATIONSHIP: _____

INSURANCE INFORMATION

INSURED NAME (if other than patient): _____ SS# _____

DATE OF BIRTH: _____ EMPLOYER: _____

WORK PHONE: _____

PARENTS OF MINOR CHILDREN - PLEASE COMPLETE

NAME: _____ NAME: _____

MOTHER

FATHER

DATE OF BIRTH: _____ DATE OF BIRTH: _____

SOCIAL SEC. # _____ SOCIAL SEC. # _____

WORK TEL# _____ WORK TEL# _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to Triangle ENT Serv., P.A. for any services furnished me by the party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the part who accepts assignment. I understand it is mandatory to notify the head care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

SIGNATURE: _____ DATE: _____

RESPONSIBILITY FOR PAYMENT OF MEDICAL SERVICES

I UNDERSTAND THAT TRIANGLE ENT SERVICES, P.A. WILL FILE MY INSURANCE AS A COURTESY. HOWEVER, I AM ULTIMATELY RESPONSIBLE FOR ALL MEDICAL FEES RELATING TO MY CARE SHOULD MY INSURANCE DENY FOR REASONS SUCH AS: AN AUTHORIZATION, DEDUCTIBLE, OR NONCOVERED SERVICE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR MY BILL.

SIGNATURE: _____ DATE: _____