CHARLOTTE EYE
EAR NOSE & THROAT
ASSOCIATES, P.A.

Account Number:_____
Physician: _____
Date: _____

PATIENT INFORMATION

Name				Employed or Student? ☐ ☐	Full or Part Time? ☐ ☐
Address				Employer	
City, State, Zip				Address	
Home Phone Number				City,State, Zip	
Date of Birth	Sex	Marital Status	Social Security #	Phone Number, Extension	
Nickname		Email Address			
Emergency Contact		Relationship		Phone Number	

RESPONSIBLE PARTY INFORMATION

Name	Phone Number
Address	Social Security Number
City, State, Zip	Relationship to Patient

PRIMARY INSURANCE

Name	Group #	Subscriber Name	
Address	Policy #	Relationship to Patient	
City,State, Zip	Primary Care Provider	Date of Birth	Sex
Phone Number for Benefits		Social Security Number	
Phone Number for Precertification	Employer	Employer Phone	

SECONDARY INSURANCE

Name	Group #	Subscriber Name	
Address	Policy #	Relationship to Patient	
City,State, Zip	Primary Care Provider	Date of Birth	Sex
Phone Number for Benefits		Social Security Number	
Phone Number for Precertification	Employer	Employer Phone	

TERTIARY INSURANCE

Name	Group #	Subscriber Name	
Address	Policy #	Relationship to Patient	
City,State, Zip	Primary Care Provider	Date of Birth	Sex
Phone Number for Benefits		Social Security Number	
Phone Number for Precertification	Employer	Employer Phone	

How did you hear about us? **Referred by:**

I certify that that the information given by me as documented above is correct. I also certify that I have been given the following Charlotte Eye, Ear, Nose & Throat Associates documents for review and that copies of these forms have been made available to me upon request.

Financial Policy Notice of Privacy Practices Non-Covered Services

By signing below, you are acknowledging that you have read and fully understand our Financial Policy, Notice of Privacy Practices, and Non-Covered Services documents.

Signature_____ **Relationship to Patient** _____ **Date** _____