

Account Number: _____

Physician: _____

Date: _____

PATIENT INFORMATION				
Name			Employed or Student? <input type="checkbox"/> <input type="checkbox"/>	Full or Part Time? <input type="checkbox"/> <input type="checkbox"/>
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:
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I certify 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 _____