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

Date:

MRN:

PATIENT

Name: _____ DOB: _____/_____/____

Address: _____ Sex: _____

_____ SSN: _____

Primary Care Provider: _____ Phone: _____-____-_____

EMERGENCY CONTACT

Contact Name:	Relationship:	Home Phone:	Work Phone:
_____	_____	____-____-_____	_____-____-_____

RESPONSIBLE PARTY

Guarantor: _____ DOB: _____/_____/____

Address: _____ Sex: _____

_____

Phone: _____-____-_____

COVERAGE

PRIMARY INSURANCE

Payor: _____ Plan: _____

Subscriber: _____ Subscriber ID: _____

SECONDARY INSURANCE

Payor: _____ Plan: _____

Subscriber: _____ Subscriber ID: _____

TERTIARY INSURANCE

Payor: _____ Plan: _____

Subscriber: _____ Subscriber ID: _____

I certify that the information given by me as documented above is correct. I also certify that I have the right to request the following Charlotte Eye Ear Nose & Throat Associates documents for review and I have the opportunity to ask any questions that I may have about the information: Financial Policy, Notice of Privacy Practices, and Non-Covered Services.

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

Signature _____ **Relationship to Patient** _____ **Date** _____