

**EAR, NOSE, AND THROAT CONSULTANTS  
OF EAST TENNESSEE, P.C.**

**Patient Information Form**

<b><u>Patient Information:</u></b>	<i>Date:</i> _____
First Name: _____ M.I.: _____ Last: _____	
Address: _____ City: _____ St.: ____ Zip: _____	
Home Phone: _(____)_____ Birth Date: _____ Age: _____ Marital Status: M S D W	
Social Security No.: _____ Medicaid No.: _____ Medicare No.: _____	
Student? <input type="checkbox"/> Yes <input type="checkbox"/> No      Sex: M F	
Employer: _____ Position: _____ Work No.: _____	

<b><u>Spouse/Guardian Information:</u></b>		
Name: _____	Relationship: _____	Phone: _____
Address: _____ City: _____ St.: ____ Zip: _____		
Employer: _____		Work Phone: _____

<b><u>Additional Information:</u></b>	
Referring Physician (if any): _____	City: _____
Address: _____ Phone: _____	
Emergency Contact (other than parent of minor or someone living at patient's address):	
Name: _____	Relationship: _____ Phone: _____
Drug Allergies: _____	
Is Patient's Condition Related to:	
Employment? (Current or Previous) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, State: _____ Date of Accident: _____	
Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: _____	
Date of Accident: _____	

**\*\* Additional Information Needed on Page 2 \*\***

**Patient Information: Page 2**

**Primary Insurance Information**

Insurance Company: \_\_\_\_\_ Is this policy under patient's name?  Yes  No

If policy is not under patient's name:

Insured Person (if not self): \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insured Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Group Name/#: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

**Secondary Insurance Information (if any):**

Insurance Company: \_\_\_\_\_ Is this policy under patient's name?  Yes  No

If policy is not under patient's name:

Insured Person (if not self): \_\_\_\_\_ Relationship: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Insured Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ St.: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Group Name/#: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

**Authorization for the Release of Information and Claims Payment:**

I authorize the release of any medical or other information necessary to process a claim for medical related services provided to patient. I also request payment of all medical benefits, including government benefits, to the attending physician. I understand that I am financially responsible to the physician for charges not covered by this assignment, including charges not covered by patient's insurance. (Patient's or authorized person's signature).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Credit Policy:**

All copayments, coinsurance, and payment for services not covered by patient's insurance policies are expected at the time of service. Please allow receptionist to copy all insurance cards for our files. Thank you.