

MANCHESTER EAR, NOSE & THROAT CENTER, LLC

WELCOME TO OUR PRACTICE

PATIENT # _____ DATE _____

Name _____
Last First MI

Patient's Social Security # _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ M ___ F ___ Marital Status _____

Family Doctor _____

Referred By _____

Home Phone _____ Cell Phone _____

Employed Full Time ___ Part Time ___ Student Full Time ___ Part Time ___

Employer's Name _____ Occupation _____

Business Phone _____ Ext. _____

Spouse or Parent Name _____

Employer _____ Work # _____

We will copy your insurance cards for the specific information.

Primary Insurance

Names _____ Policy # _____ Group _____

Relationship to Patient Self Spouse Parent

Secondary Insurance

Name _____ Policy # _____ Group _____

Relationship to Patient Self Spouse Parent

NOTIFICATION REQUIRED BY THE FEDERAL GOVERNMENT

Privacy Notification and Insurance Authorization

I authorize the routine release of my medical information for purposes of treatment, billing and routine health care operations. I understand that my medical information will not be released for any other purpose without my consent. I request that payment of authorized health care benefits be made to the Providers of Manchester Ear, Note & Throat Center, LLC. I authorize any medical information about me be released to my health insurance agent any information needed to determine the benefits payable for related services. **I am aware that I am responsible to understand my individual insurance benefits and that I am liable for any non-covered services.**

Signature: _____ Date: _____

