ENT SPECIALISTS OF ARIZONA, P.C.

PERSONAL INSURANCE INFORMATION

PATIENT NAME: _____ DOB: _____

Parent/Guardian Name : _____

Address	City	State	Zip
		AZ	

Home phone	Cell phone	I give my permission to be contacted at/by:	Ok to leave message?
		___ Home ___ Cell ___ Email ___ Text	__yes __ no

E-MAIL _____ What is your primary language? _____

Marital Status: __ Married __ Single __ Divorced __ Widowed __ Separated Gender __ male __female

INSURANCE INFORMATION (Must be filled out completely for verification purposes) **____ Check HERE if you have NO insurance**

Primary insurance company	Policyholder name	Policyholder DOB	Patient relationship to insured
			__Self __Spouse __ Child __ Other
Policy #		Group #	
Secondary insurance company	Policyholder name	Policyholder DOB	Patient relationship to insured
			__Self __Spouse __ Child __ Other
Policy #		Group #	

We are required to ask this question about your race: __ White or Caucasian __ Hispanic or Latino __ Black Hispanic or Latino __ Black or African American __American Indian or Alaska Native __ Native Hawaiian or Other Pacific Islander __ Asian __ Other __ I prefer to not answer

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the release and/or discussion of my health information with the following persons.

Name_____ Relationship _____ Phone number _____

Name_____ Relationship _____ Phone number _____

Do you have an Advance Directive? ____ Living Will ? ___ Medical Power of Attorney? ___

__ Do not discuss my information with anyone. (**Information may be released per HIPAA guidelines for treatment, payment, and operations**)

PHARMACY

Name of Pharmacy	Address/Cross Streets:	Phone number

EMERGENCY CONTACT

Name_____ Relationship _____ Phone number _____

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to of all the terms herein.

x_____ _____

Signature of patient, responsible party Date

NEW PATIENTS: Please indicate how you heard about us. Thank you!

☐ Physician ☐ Friend ☐ Word of mouth ☐ Insurance company ☐ Internet ☐ Other:

Referring Physician: **Primary Care Physician**: