

ENT SPECIALISTS OF ARIZONA

PATIENT REGISTRATION: (PLEASE PRINT)

NAME:	SEX:	AGE:	BIRTH DATE:
ADDRESS:	SS#		
CITY:	STATE:	ZIP:	
HOME PHONE: ()	WORK PHONE: ()		EMPLOYER:
CELL PHONE: ()	ADDRESS:		
	CITY:	STATE:	ZIP:

IN CASE OF EMERGENCY CALL

Relationship:

HOME PHONE: ()	WORK PHONE: ()
MARITAL STATUS:	SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/>
REFERRED BY:	FAMILY DOCTOR:

WHY ARE YOU SEEING THE DOCTOR TODAY?

HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN SEEN AT THIS OFFICE BEFORE: yes Name(s) _____ no

RESPONSIBLE PARTY INFORMATION: Complete in full even if the same as above.

NAME:	RELATIONSHIP TO PATIENT	S.S. #
ADDRESS:	OCCUPATION:	
CITY:	STATE:	ZIP:
HOME PHONE: ()	EMPLOYER:	
WORK PHONE: ()	ADDRESS:	
	CITY:	STATE: ZIP:

GUARDIAN INFORMATION: Complete if different than responsible party information.

NAME:	RELATIONSHIP TO PATIENT	S.S. #
ADDRESS:	OCCUPATION:	
CITY:	STATE:	ZIP:
HOME PHONE: ()	EMPLOYER:	
WORK PHONE: ()	ADDRESS:	
	CITY:	STATE: ZIP:

RELATIONSHIP:

INSURANCE:

Primary Insurance			Secondary Insurance		
Address			Address		
City	State	Zip:	City	State	Zip:
Subscriber Name:	<small>Subscriber Date of Birth:</small>		Subscriber Name:	<small>Subscriber Date of Birth:</small>	
Relationship to Subscriber: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other			Relationship to Subscriber: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		
Subscriber ID No.	Group No.		Subscriber ID No.	Group No.	
Name on ID Card			Name on ID Card		
Subscriber Employer:			Subscriber Employer:		

PAYMENT AUTHORIZATION AND AGREEMENT:

I authorize release of any medical information and/or records necessary to process this claim. I understand that my medical insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor. I am ultimately responsible for medical fees incurred during my care or the care of my dependents. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection agency costs and reasonable attorney fees incurred. I hereby authorize ENT Specialists of Arizona to apply for benefits on my behalf for covered services rendered by him/her or his/her order. I also assign all benefits directly to the doctor. I certify that the information that I have reported above is correct and true. I permit a copy of this authorization to be used in the place of the original. My signature below also authorizes my consent to treat my minor child.

Date _____ Signature _____

OFFICE ONLY	FRONT DESK Initials _____	Date _____
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NO CHANGES _____	PATIENT Initials _____	Date _____
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