PATIENT #: _____

Ear Nose and Throat Consultants of Nevada
Patient History and Agreement-Adult

Patient: (please print) Cell Phone _____
Name (include middle initial) _____ Home Phone _____
Sex M F Date of Birth _____ Age _____ Social Security Number _____
Address _____
City _____ State _____ Zip _____
Occupation _____ Employer _____ Work Phone _____
Work Address _____ City _____ State ___ Zip _____
Race / Ethnicity: _____ Language: _____

Spouse:
Name (include middle initial) _____ Home Phone _____
Sex M F Date of Birth _____ Age _____ Social Security Number _____
Address _____
City _____ State _____ Zip _____
Occupation _____ Employer _____ Work Phone _____
Work Address _____ City _____ State ___ Zip _____

Insurance Information:
Primary Insurance _____ Subscriber _____
I.D. Number _____ Group Number _____ Phone _____
Claims Mailing Address _____

Secondary Insurance _____ Subscriber _____
I.D. Number _____ Group Number _____ Phone _____
Claims Mailing Address _____

Other Information:
Referred By _____ Primary Care Physician _____
Emergency Contact _____ Phone _____
Nearest relative not living with you _____ Phone _____

Financial Agreement and Authorization for Treatment

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. All professional services are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor.

A copy of the signature is as valid as the original.

_____ PATIENT SIGNATURE DATE

_____ GUARANTOR SIGNATURE DATE

_____ REGISTERED BY INITIALS