

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

Patient: (please print)

Name (include middle initial) _____ Cell Phone _____
 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: _____
 Email Address: _____

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