UPDATE ___/___/___ DATE___/___/___

PATIENT NAME: _____
first middle last

ADDRESS:_____
Street Route or PO Box # City State Zip

AGE _____ DATE OF BIRTH ___/___/___ TELEPHONE #_____ ALT. TEL. # _____ RACE_____

CIRCLE: MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED SEPARATED SOCIAL SECURITY #_____

**(IF PATIENT IS A CHILD PLEASE SKIP TO NEXT SECTION)**

PATIENT'S EMPLOYER _____ ADDRESS _____

PHONE# _____ LENGTH OF EMPLOYMENT _____ SHIFT _____

INSURANCE COMPANY_____ CIRCLE: SINGLE OR FAMILY COVERAGE

NAME OF SPOUSE_____ DATE OF BIRTH___/___/___ SOCIAL SECURITY # _____

SPOUSE'S EMPLOYER _____ ADDRESS _____

PHONE# _____ LENGTH OF EMPLOYMENT _____ SHIFT _____

SPOUSE'S INSURANCE COMPANY_____ CIRCLE: SINGLE OR FAMILY COVERAGE

**(IF PATIENT IS A CHILD PLEASE LIST GUARDIAN INFORMATION)**

FATHER_____DATE OF BIRTH___/___/___

ADDRESS_____
STREET

_____
CITY STATE ZIP

EMPLOYER _____

ADDRESS_____PHONE# _____

LENGTH OF EMPLOYMENT_____SHIFT _____

INSURANCE COMPANY_____
CIRCLE: SINGLE OR FAMILY COVERAGE

HOW MUCH IS YOUR DEDUCTIBLE PER PERSON?_____

FATHER'S SOCIAL SECURITY #_____

MOTHER_____DATE OF BIRTH___/___/___

ADDRESS_____
STREET

_____
CITY STATE ZIP

EMPLOYER _____

ADDRESS_____PHONE# _____

LENGTH OF EMPLOYMENT_____SHIFT _____

INSURANCE COMPANY_____
CIRCLE: SINGLE OR FAMILY COVERAGE

HOW MUCH IS YOUR DEDUCTIBLE PER PERSON?_____

MOTHER'S SOCIAL SECURITY #_____

**EMERGENCY CONTACT** Name_____ Address_____
**NOT IN THE SAME HOUSEHOLD**
Telephone # _____ Relationship to you_____ Employer_____ Location_____

Is your problem a result of an accident? Yes_____ No_____ Date of Accident ____/____/____

Is your problem related to an auto accident? Yes_____ No_____ Date of Accident ____/____/____

**Privacy Notice of Greenwood ENT Center**: Your information is confidential. Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence. We protect your information. We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords and virus/firewall protection of our computerized databases and compliance audits to ensure staff compliance. Within our practice your information is limited to only those who need it to perform their jobs in service to you.

I authorize Greenwood Ear, Nose and Throat Center to furnish, to my insurance company, medical and other information necessary to process insurance claims. I also authorize medical payments to be paid directly to this practice for services rendered at any time I do not pay my bill in full at the time of the service. I give Greenwood ENT my consent for medical treatment and to share medical information with my referring physician / family physician. I also authorize Greenwood ENT to share medical information with ancillary medical personnel only when it is needed to complete my medical treatment (ex. school nurse or special services/hearing coordinator or case worker, hearing aid manufacturers, speech pathologist, medical laboratory, employee health).

Greenwood ENT requires payment for services on the day the services are performed. Co-pay's are due prior to being seen by our professionals. We have contracted with several insurances companies and electronically file these claims as a service to our patients. I am aware that any account that goes over 60 days with no payment will be placed into the collection process and if I should have an account that is not paid as promised, my account will be charged a collection fee (minimum of $35.00) if the account is turned over to Greenwood ENT's Collection agency.

Date_____ Signature _____



**WE NEED TO MAKE COPIES OF ALL INSURANCE CARDS**