



PATIENT INFORMATION

ID# \_\_\_\_\_

Northwest ENT and Allergy Center

PATIENT NAME: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Social Security No. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Patient's Age \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ MARITAL STATUS \_\_S \_\_M \_\_D \_\_W

Which Doctor Are You Seeing Today? \_\_\_\_ Dr. Locandro \_\_\_\_ Dr. Sutton \_\_\_\_ Dr. Parikh \_\_\_\_ Dr. Kauffman

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ Phone No. \_\_\_\_\_

REFERRING PHYSICIAN if different from PCP: \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_

RESPONSIBLE PARTY NAME: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Social Security No. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

ZIP Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_ Policy Holder \_\_\_\_\_ \*\*

Policy ID# \_\_\_\_\_ Group No. \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ Policy Holder \_\_\_\_\_ \*\*

Policy ID# \_\_\_\_\_ Group No. \_\_\_\_\_

\*\* If Policy Holder is not the Patient, We Must Have the Following Information to File Your Claim\*\*

POLICY HOLDER: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_ Male \_\_\_\_ Female Social Security No. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PATIENT'S RELATIONSHIP TO POLICY HOLDER \_\_Spouse \_\_ Child \_\_ Other \_\_\_\_\_

PATIENTS EMPLOYER \_\_\_\_\_

PAYMENT OF ALL CO-PAYMENTS, DEDUCTIBLES, AND ANY OTHER PATIENT RESPONSIBILITY FEES ARE DUE WHEN SERVICES ARE RENDERED. IF YOU HAVE A QUESTION ABOUT FEES, PLEASE CHECK WITH US.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Northwest ENT and Allergy Center to diagnose and treat me. I also authorize Northwest ENT and Allergy Center to release medical and/or any other information to my insurance carrier, Medicare, and/or the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for payment on Medicare/Insurance Company Claims for services rendered by Northwest ENT and Allergy Center and/or its physicians. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to Northwest ENT and Allergy Center and/or its physicians. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. (Section 1128B of the SS Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). I have also been informed of my rights to privacy via posters and handouts contained within this office as mandated under the current federal HIPAA laws.

\_\_\_\_\_  
Patient or Legal Guardian Signature (If patient under 18 years old)

\_\_\_\_\_  
Date