

# New Patient Form

ENT & SINUS CENTER

Date \_\_\_\_\_

## Patient Information

Patient's Name \_\_\_\_\_  
Last Name First Name Middle Name Name you go by

Street \_\_\_\_\_

City, State, Zipcode \_\_\_\_\_ Home Phone \_\_\_\_\_ include area code

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_ Driver's Lic. # \_\_\_\_\_ Marital Status \_\_\_\_\_  
mm/dd/yyyy

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ include area code

Spouse's Name \_\_\_\_\_  
Last Name First Name Middle Name Name goes by

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ include area code

## Emergency Contact

Contact's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ include area code

## Insurance Information

Insurance #1 \_\_\_\_\_

Group # \_\_\_\_\_ Contract # \_\_\_\_\_ Co-pay \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN \_\_\_\_\_  
mm/dd/yyyy

Insurance #2 \_\_\_\_\_

Group # \_\_\_\_\_ Contract # \_\_\_\_\_ Co-pay \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ SSN \_\_\_\_\_  
mm/dd/yyyy

## Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature \_\_\_\_\_ Date \_\_\_\_\_