

VILLA RICA EAR, NOSE, & THROAT, LLC

Patient information

Name _____

Home Phone _____

Street Address _____

Work Phone _____

City _____ State _____

Cell Phone _____

Zip Code _____ County _____

Date of Birth _____

Mailing Address _____

Social Sec # _____

Employer _____

Emergency contact/Number _____

Street Address _____

Occupation _____

City _____ State _____

Primary Care Physician _____

Zip Code _____

Referred by _____

SPOUSE'S INFORMATION

Name _____ Date of Birth _____ Social Sec# _____

Employer _____ Work Phone _____

Street Address _____ City _____ State _____ Zip Code _____

PARENT 'S INFORMATION, if patient is a minor

Father's Name _____

Mother's Name _____

Street Address _____

Street Address _____

City _____ State _____ Zip Code _____

City _____ State _____ Zip Code _____

Date of birth _____ Social Sec# _____

Date of birth _____ Social Sec# _____

Employer _____

Employer _____

Work Phone _____ Cell Phone _____

Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

Name of Primary Insurance company _____

ID# _____

Name of Insured _____

Deductible or copay _____

Group Number _____

Relationship to patient _____

Name of Secondary Insurance company _____

ID# _____

Name of Insured _____

Deductible or copay _____

Group Number _____

Relationship to patient _____

AUTHORIZATION TO TREAT AND INSURANCE AUTHORIZATION

I assign to Villa Rica Ear, Nose, & Throat, LLC all payments for medical services rendered to me or my dependents. I authorize Villa Rica Ear, Nose, & Throat, LLC to furnish information to insurance carrier, physicians or hospital concerning illness and treatments. I authorize any physician, hospital or medical care facility to provide all information on medical history and treatment to Villa Rica Ear, Nose, & Throat, LLC. I authorize photocopies of this form to be valid as the original. I have read and understand the above and give Villa Rica Ear, Nose, & Throat, LLC permission to treat me or my dependents.

Signature _____

Date _____