

**WE ASK THAT PAYMENT BE MADE AT THE TIME OF EACH OFFICE VISIT
WE ACCEPT THE FOLLOWING: MASTERCARD, VISA, CASH OR CHECK**

PATIENT NAME _____ SEX _____ AGE _____ BIRTH DATE _____

ADDRESS _____
Number and Street Apt. # City State Zip

HOME PHONE # _____ CELL # _____ SOC. SECURITY # _____

PATIENT'S EMPLOYER _____
Name Work Phone

NAME OF PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT) _____

ADDRESS & PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER & PHONE _____

NAME AND PHONE # OF NEAREST RELATIVE OR FRIEND _____

NAME OF FAMILY MEMBER PREVIOUSLY SEEN IN OUR OFFICE: _____ DATE _____

IF PATIENT IS UNDER 18 YEARS OF AGE:

FATHER 'S NAME _____ SOC. SECURITY # _____

EMPLOYER _____ WORK / CELL # _____

MOTHER'S NAME _____ SOC. SECURITY # _____

EMPLOYER _____ WORK / CELL # _____

Who referred you to us? _____

Who is your Primary Care Physician? _____ **Phone** _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ **POLICY / ID #** _____

Insured's Name _____ **SSN:** _____

Insured's Date of Birth _____ **Insurance Co. Phone #** _____ **GROUP #** _____

SECONDARY INSURANCE _____ **POLICY / ID #** _____

Insured's Name _____ **SSN:** _____

Insured's Date of Birth _____ **Insurance Co. Phone #** _____ **GROUP #** _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

1) I authorize Arthur Torsiglieri, MD Donald, Cote, MD and/or Susan Smith, DO to release to my insurance carriers any information requested concerning my examination or treatment, and I understand that I am responsible for any charges not covered by my insurance.

2) I hereby authorize payment directly to Arthur Torsiglieri, MD and/or Donald Cote, MD and/or Susan Smith, DO for surgical and medical benefits payable for the services performed.

3) I authorize the administration of any anesthetics and analgesics (eardrops and medication) that the doctor / PA advises.

4) I understand that a reasonable fee will be added each month to accounts over 120 days old.

5) My signature below indicates that I am aware of ENT Specialists, LLC's Privacy Policy and it's availability for my review.

6) I authorize ENT Specialists staff to contact me AND/OR leave a message at: home work

7) Email address _____

SIGNATURE OF PATIENT OR GUARDIAN

PRINTED NAME OF GUARDIAN

DATE