Ear, Nose & Throat Associates of South Florida – Patient Information

Please Fill Out Form Completely

****Race and Ethnicity questions are required to be asked to the patient by the Federal Government**

Patient Name: _____ Date of Birth: _____ Age: _____

Sex: F___ M ___ SSN: _____ Marital Status: M ___ S___ D ___ W___ Other___

Please check appropriate response:

* *Race: American Indian/Alaska Native____ Asian____ Black/African American____ Declined to answer ____

Native Hawaiian/Pacific Islander____ Other Race___ White____

Please check appropriate response:

**Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino: ____ Declined to answer: _____

Religion: _____ Primary Language: _____ Maiden Name: _____

Responsible Party/Guarantor Name: _____

Patient's Address: _____

Street City, State Zip

Patient's 2nd Address: _____ ____Full-time ____Part-time Resident

Patient's Phone (Primary) (____)_____ Patient's Phone (Cell) (____)_____

Please check your preference on how to contact you: Home Phone:___ Cell Phone: ___ Other: _____

Email Address: _____ Employer Name: _____

Emergency Contact: _____ Relationship: _____ Phone# _____

Whom may we thank for referring you? _____

Referring Physician: _____ Primary Care Physician: _____

Is this visit related to a Work Accident____ Auto Accident _____ or Other Accident _____

Pharmacy Name_____ Address: _____ Tele# _____

Insurance Information

Primary Insurance Company: _____ Subscriber's Name: _____

Relationship to Patient: _____ Date of Birth: _____ ID# _____ Group# _____

Secondary Insurance Company: _____ Subscriber's Name: _____

Relationship to Patient: _____ Date of Birth: _____ ID# _____ Group# _____

I consent to medical treatment for myself, my child or the above named minor, for which I am legally responsible. I authorize the release of any medical information to any insurance for the purpose of filing my medical/surgical claim. I authorize payment on behalf of myself, and/or my dependents to be made directly to Ear, Nose & Throat Associates of South Florida, PA. I further understand that I am financially responsible for any services deemed Non Covered by my insurance company, and deductibles, co-pays, and co-insurance is due at the time of service. I further understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

I also authorize my Physician and Ear, Nose & Throat Associates of South Florida to photograph me for medically related documentation purposes. Yes_____ No_____

Signature: _____ Date: _____

Ear, Nose and Throat Associates
of South Florida, P.A.
Caring For Our Patients Since 1963
www.entsf.com

Place label here/or patient full name/account number

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ **No Known Drug Allergies**

MEDICATIONS: Date: _____ Reconciled by:_____

Medication Name	Rx = Prescription OTC = Over the Counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all test results ordered by your care provider and to confirm scheduled appointments. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

Please check response: ☐ **Yes** ☐ **No**

Patient/Guardian Signature: _____

Print Patient Name: _____ **D.O.B:**_____