ENT Voice & Sinus Center of Nevada

PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle Initial _____
Address: _____ Home Phone: _____
City: _____ State _____ Zip _____ Cell Phone: _____
Date of Birth: _____ Social Security # _____ Work Phone: _____
□ Male □Female □American Indian □Asian □African American □White □ Other
Ethnicity □Hispanic/Latino □Not Hispanic/Latino
Email: _____ □ Single □ Married □ Divorced □ Widowed □ Separated
Patient's Employer: _____ Occupation: _____
Work Related Injury: □ Yes □ No Automobile Accident □ Yes □ No Date of Injury/Accident: _____
Retired □ Yes □ No Advance Directive □ Yes □ No Copy on File □ Yes □ No
Referred by: _____
Emergency Contact: _____ **Relationship** **Phone Number**

IF DIFFERENT FROM ABOVE – POLICY HOLDER/INSURED INFORMATION – Primary Insurance

Insured Person Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip _____
Date of Birth: _____ Social Security # _____ Relationship to Patient _____
Employer: _____ Work Phone _____
Employer Address: _____
Primary Insurance: _____ Phone Number _____
Group # _____ Policy # _____

IF DIFFERENT FROM ABOVE – POLICY HOLDER/INSURED INFORMATION – Secondary Insurance

Insured Person Name: _____ Phone: _____
Address: _____
Date of Birth: _____ Social Security # _____ Relationship to Patient _____
Secondary Insurance: _____ Phone Number _____
Group # _____ Policy # _____

AUTHROIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance accompany and I assign benefits to Susan Schwartz, DO, PC. We will gladly file your insurance claim, however payment for copays and deductibles are required at the time of services are rendered. We cannot guarantee payment to Susan Schwartz, DO, PC. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Susan Schwartz, DO, PC. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency. **A $45 fee will be charged for no-show appointments and appointments not cancelled 24 hours in advance. There is a $45 fee for all bad checks returned by the bank.**

I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmissions of medical records if necessary.

SIGNATURE _____ DATE: _____