Welcome to: Ashland ENT, Allergy & Hearing Aid Center

To better serve you, please complete as accurate as possible.

Patient Information

Today's Date:	Account#:	SSN:
First Name:	MI:	Last Name:
Address:		
Zip Code:	City:	State:
Date of Birth:	Age:	Marital Status:
Sex: F M	Email:	
Home Phone:	Work:	Cell:
Primary Care Physician's Name: Referring Physician's Name:		PCP Phone #: Referring Phone #:
In the event of an Emergency please contact:	Name:	
Relationship:	Phone:	

Patients with Medicare: Is your spouse actively working and have health insurance coverage: Yes No

Insurance information: Effective:_____ Copay:_____

Please present your insurance card(s) to the receptionist. Please provide complete information.

Primary Ins:	Ins ID:	Group No:
Subscriber Name:	Subscriber SSN:	
Subscriber DOB:	Relation to Patient:	
Employer:	Employer Phone:	
Secondary Ins:	Ins ID:	Group No:
Subscriber Name:	Subscriber SSN:	
Subscriber DOB:	Relation to Patient:	
Employer:	Employer Phone:	

Guarantor Information: (Person to be billed, if different than patient)

First Name:	MI:	Last Name:
Address:		Phone:
SSN:	DOB:	Gender: M F

How did you hear about us? _____

Patient's or Authorized Person's Signature:

I the undersigned give my authorization to treat and assign directly to Ashland ENT, Allergy & Hearing Aid Center all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.
I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Patient/Guardian Signature:_____ Date: _____