

# WILMINGTON EAR NOSE AND THROAT ASSOCIATES

## Patient Information

Patient Name: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Address City State Zip Code

Street Address: \_\_\_\_\_  
(if different from above) Address City State Zip Code

Telephone#: (\_\_\_\_) \_\_\_\_\_ Work#: (\_\_\_\_) \_\_\_\_\_ Cell#: (\_\_\_\_) \_\_\_\_\_

Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male [ ] or Female [ ]

Patients Employer: \_\_\_\_\_ Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow

Race: [ ] White/Caucasian [ ] African American [ ] Hispanic [ ] Asian [ ] Other: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Social Security# \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(For Insurance Purposes Only)

## Guarantor (For Patients under 18 years of age or insurance policy holder's information)

Guarantors Name: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Address City State Zip Code

Telephone#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Guarantors Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male [ ] or Female [ ]

## Responsible Party (For Patients under the age of 18)

Fathers Name: \_\_\_\_\_ Mothers Name: \_\_\_\_\_

Fathers Social Security#: \_\_\_\_\_ Mothers Social Security#: \_\_\_\_\_

Fathers Date of Birth: \_\_\_\_\_ Mothers Date of Birth: \_\_\_\_\_

Fathers Employer: \_\_\_\_\_ Mothers Employer: \_\_\_\_\_

Employers Phone: (\_\_\_\_) \_\_\_\_\_ Employers Phone: (\_\_\_\_) \_\_\_\_\_

## Insurance Information

(Primary) Name of Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

(Secondary) Name of Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

(Tertiary) Name of Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

## General Information

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone#: (\_\_\_\_) \_\_\_\_\_

### Authorization to pay benefits to Physician

I hereby authorize payment directly to the physician of surgical and medical benefits, if any, otherwise payable to me for this service as described including Medicare Benefits. I further authorize the release of medical information about me to process my medical claims in accordance with the Notice of Privacy Practice furnished to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Medical Records Release Authorization

I hereby authorize Wilmington Ear Nose and Throat Associates, PA to obtain and release any information, needed or obtained in the course of my treatment to physicians and/or medical providers where treatment is or may be rendered. I also hereby authorize my physician to release any information in the course of my treatment to process insurance claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned hereby acknowledges receipt of a copy of the Notice of Privacy Practices of Wilmington Ear Nose and Throat Associates, PA.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_