Ear, Nose and Throat Physicians and Surgeons, PA
Dr. J Byer, Dr. R Lee, Dr. J Murray, Dr. M Stock

Demographic Information			
Patient Name:		DOB:	Sex:
Mailing Address:	City:	St:	Zip:
Phys Address:			
E-mail:		SS#	
Home Phone:	Cell Phone:	Work Phone:	
May we leave messages on all numbers? Y N	Marital Status	Employed: Full time / Part time / Retired / Student / Not Emp	
Preferred Language:	Ethnicity	Race:	
I have Authorized ENT Physicians & Surgeons to speak to the following on my behalf:			
Primary Care Physician			
Primary Care Physician:	Phone::		
Address:	City::	St: :	Zip:
Referring Physician (if different)			
Referring Dr:	Phone		
Address:	City:	St:	Zip:
Responsible Party's Information (*if patient is under the age of 18 or payer is different)*			
Guarantor:	DOB:	Sex:	
Address:	City:	St:	Zip:
Home Phone:	Cell Phone:		
Work Phone:			
Medical Insurance Information	**Insurance Card Scanned** ☐		
Primary Insurance:	Ins Phone:		
Address:	City:	St:	Zip:
Cert No:	Group No:		
Subscriber:	DOB:		
Secondary Insurance:	Ins Phone:		
Address:	City :	St :	Zip:
Cert No**:**			
Subscriber:	DOB:		
Emergency Contact Information			
Emergency Contact	DOB		
Home Phone:	Cell Phone:		

I understand that my signature authorizes payment by the insurance to the provider, I authorize the release of all medical information necessary to pay insurance claims. I authorize the release of all medical information necessary for continuity of patient care. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collections monies owed, including court costs and attorney fees.

Signature (patient or Legal Guardian)	Date