



PATIENT INFORMATION SHEET

DATE: _____
PATIENT NAME: _____ HOME PHONE: _____
ADDRESS: _____ WORK PHONE: _____
ADDRESS: _____ DATE OF BIRTH: _____
CITY: _____ STATE: _____ SOC. SEC. #: _____
ZIP CODE: _____ SEX: _____ MARITAL STATUS: _____
EMPLOYER OR PHYSICIAN
SCHOOL NAME: _____ REQUESTING CONSULT: _____
FAMILY PHYSICIAN: _____ REFERRED BY: _____
How did you hear about our office: _____

HUSBAND (OR FATHER IF PATIENT IS UNDER 18) NAME: _____ SS#: _____
EMPLOYER: _____ DATE OF BIRTH: _____
WORK PHONE #: _____

WIFE (OR MOTHER IF PATIENT IS UNDER 18) NAME: _____ SS#: _____
EMPLOYER: _____ DATE OF BIRTH: _____
WORK PHONE #: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____ RELATIONSHIP: _____

PLEASE PRESENT A COPY OF ALL INSURANCE CARDS TO RECEPTIONIST

IF YOU HAVE MEDICARE, PLEASE ANSWER QUESTIONS ON NEXT PAGE

1. INSURANCE COMPANY: _____ 2. INSURANCE COMPANY: _____
INSURED NAME: _____ INSURED NAME: _____
INSURED ID#: _____ INSURED ID#: _____

PREFERRED METHOD OF PAYMENT

CHECK CASH CREDIT CARD (M/C OR VISA)

AUTHORIZATIONS – Please read and sign:

I authorize payment to ENT Carolina, P.A., or directly to me for services rendered. I authorize such exams, treatments and medications as may be prescribed by the designated physician. I understand that I am financially responsible for all charges for treatment rendered to me, whether covered by insurance or not. I authorize the release of any medical information requested by my insurance company or any public agency which assists in payment for my medical care. I authorize release of any medical information to my primary care physician.

(Parent sign if minor) SIGNED: _____ DATE: _____



MEDICARE MSP QUESTIONNAIRE

PATIENT'S NAME: _____

DATE OF SERVICE: _____

ARE YOU ENROLLED IN HOSPICE? YES _____ NO _____

ARE YOU ENROLLED IN A MEDICARE HMO? YES _____ NO _____

ARE YOU OR YOUR SPOUSE CURRENTLY EMPLOYED? YES _____ NO _____

ARE YOU COVERED UNDER GROUP HEALTH INSURANCE THROUGH YOUR OR YOUR SPOUSE'S EMPLOYER? YES _____ NO _____

IS YOUR CURRENT ILLNESS/INJURY WORK RELATED? YES _____ NO _____

IS YOUR CURRENT INJURY ACCIDENT RELATED? YES _____ NO _____

IF YES, TYPE OF ACCIDENT: AUTOMOBILE _____ NON-AUTOMOBILE _____