Marshall ENT & Allergy

PATIENT INFORMATION

Patient's Name (First, Middle, Last)			
Patient's Address			
City, State		**Zip**	
Home Phone	**Cell Phone**		
Email Address			
Date of Birth	**Age**	**Sex** ❒ M ❒ F	**SS#**
Single ❒	**Married** ❒	**Employed** ❒	**Full-Time Student** ❒
Employer	**Employer's Phone**		

Emergency/Reschedule Contact
(not in same household)

Name	**Relationship**
Home Phone	**Work Phone**

FILL IN FOR HUSBAND OR WIFE

Spouse's Name	
Employer	**Employer's Phone**

FILL IN IF PATIENT IS A MINOR

Father's Name (First, Middle, Last)	
Employer	**Employer's Phone**
Mother's Name (First, Middle, Last)	
Employer	**Employer's Phone**

Person Responsible for Account

Name	**Relationship to Patient**

INSURANCE

Name on Primary Insurance Card		**Date of Birth**
Name on Secondary Insurance Card		**Date of Birth**
Accident ❒ Yes ❒ No	**Industrial Injury** ❒ Yes ❒ No	**Automobile Injury** ❒ Yes ❒ No

CONTACT INFORMATION:

I understand it is **my responsibility** to keep contact information up-to-date with Marshall ENT & Allergy.

PAYMENT TERMS:

The patient or person responsible for the account agrees to pay all charges for services at the completion of such services. All co-pays and deductibles are due at the time of service. If payment is not received the account may be placed for collection. The person responsible for the account agrees to pay the cost of collection.

AUTHORIZATION:

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits directly to Maury B. Bray III, MD. We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. Your health information also may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

NOTICE OF PRIVACY PRACTICES:

Do you want to receive a copy of our privacy policy? Yes ❒ No ❒

_____ _____
Signature of Patient or Representative Date Signed

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