CRYSTAL COMMUNITY E.N.T • PATIENT INFORMATION & AUTHORIZATIONS

PATIENT NAME: _____ **GENDER**: M F **DOB**: _____

ADDRESS: _____ **CITY**: _____ **STATE**: _____

ZIP CODE: _____ **EMAIL**: _____

HOME #: _____ **CELL #**: _____

EMPLOYER: _____ **WORK PHONE #**: _____

Marital Status : □MARRIED □DIVORCED □WIDOW □OTHER **SSN**: _____

SPOUSE'S NAME: _____ **DATE OF BIRTH**: _____

PARENT OR GUARDIAN NAME: _____

RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT: NEAREST RELATIVE, NEIGHBOR, OR FRIEND NOT LIVING WITH YOU

NAME: _____ **PHONE #**: _____

PRIMARY INSURANCE: _____ **ID#** _____
(IF NOT SUBSCRIBER PLEASE FILL OUT BELOW)
SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

SECONDARY INSURANCE: _____ **ID#** _____
(IF NOT SUBSCRIBER PLEASE FILL OUT BELOW)
SUBSCRIBER'S NAME: _____ DOB: _____ SEX: _____

PATIENT AUTHORIZATIONS

INSURANCE & FINANCIAL AUTHORIZATIONS:
I assign all medical and/or surgery benefits, to include "major medical" benefits, which I am entitled inclusive of Medicare and all other health insurance payments to Crystal Community E.N.T., PA that it is entitled. Payment is due at the time services are provided unless other options or plan(s) have been made prior to visit. I understand you do not accept assignment in the case of liability actions.
I understand that I am responsible to be knowledgeable of my insurance coverage, deductible, and co-pays for any service provided to me and that I am financially responsible for payment to Crystal Community E.N.T., PA. Refunds from services charged on a credit card will be returned to the same credit card.
I have read and accept the terms of this policy.

TREATMENT AUTHORIZATION:
I hereby give Crystal Community ENT consent for medical treatment.

MEDICAL RECORDS AUTORIZATION:
I authorize the release of medical record information to: 1) the above named insurance companies 2) any physician who has participated in my health care, and 3) to any physician to whom I may subsequently be referred.

Patient or Legal Guardian Signature: _____ **Today's Date:** _____