

Patient's Information

Patient Name: _____

Date of Birth: _____ Sex: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Family Dr: _____ Phone: _____

Address: _____

Insurance Information

Insurance 1: _____ HMO Referral #: _____

Policy #: _____ Group #: _____

Insured Name: _____ Insured D.O.B: _____

Relationship to Insured: _____

Insurance 2 _____ HMO Referral #: _____

Policy #: _____ Group #: _____

Insured Name: _____ Insured D.O.B: _____

Relationship to Insured: _____

Assignment of Benefits

Every effort will be made to process billing through your insurance plan, but it ultimately the patient's responsibility for payment.

I authorize payment of medical benefits for myself directly to Bethlehem ENT Associates for professional services rendered

Signature: _____ Date: _____