

Cape Cod Ear, Nose and Throat Specialists

Patient Information

Patient's Name: _____ Maiden _____
Last, First, Middle
Social Security No.: _____ - _____ - _____ Date of Birth _____ Age _____ () Female () Male
Address: _____ Zip Code _____ - _____
Mailing Address (if different from above): _____ Zip Code _____ - _____
Home Phone (____) _____ - _____ 2nd Phone No.: (____) _____ - _____
() Work () Cell () Pager
Employer: _____ Address: _____
Primary Care Dr. _____ Address: _____

If patient is a minor, Responsible Person: (required information)

Name: _____ () Male () Female Date of Birth _____
Social Security No.: _____ - _____ - _____ Home Phone No.: (____) _____ - _____
Address: _____ 2nd Phone No.: (____) _____ - _____
() Work () Cell () Pager
Employer: _____ Address: _____
Relationship to Patient: _____

Primary Insurance Company: _____ Effective Date: _____

Address to send claim: _____

Policy No.: _____ Group No.: _____

Subscriber Name: _____ Subscriber's Social Security No.: _____ - _____ - _____

Secondary Insurance Company: _____

Address to send claim: _____

Policy No.: _____ Group No.: _____

Subscriber Name: _____ Subscriber's Social Security No.: _____ - _____ - _____

Financial Agreement:

I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits.

Assignment of Benefits: *I request that payment of authorized medical benefits be made on my behalf directly to Cape Cod ENT Specialists for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or other insurer, any information needed to determine these benefits payable for related services. This Assignment will remain in effect until revoked by me in writing. A photocopy of this Agreement is to be considered as valid as the original.*

I have read this information and I understand it.

Signature X _____ Date: _____

Turn Over →