Ear, Nose & Throat
Surgical Associates, S.C.
1520 North Meade Street, Appleton, WI 54911
(920) 734-7181

PATIENT INFORMATION FORM

Not filling out this form may delay or result in non-payment of insurance benefits leaving you responsible for services rendered

Last Name	First Name	MI	Date of Birth / Age
Street Address	City	State	Zip
Phone #1 ☐ Home ☐ Work ☐ Cell ( )	Phone #2 ☐ Home ☐ Work ☐ Cell ( )	Social Security Number	
Gender ☐ Male ☐ Female	Marital Status ☐ S ☐ M ☐ W ☐ D	Primary Care Physician -	
Emergency Contact	Phone No. ( )	Referring Physician -	

PARENTS/LEGAL GUARDIAN (IF PATIENT IS A MINOR)

☐ Guardian or ☐ Mother ☐ Father	Last Name	First	MI
Address	City	State	Zip
Phone No	Present Employer		

HEALTH INSURANCE INFORMATION

Primary Insurance		Patient is ☐ Policyholder ☐ Spouse ☐ Dependent	
ID or Subscriber #		Group #	
Policyholder's Name	DOB	SSN	
Policyholder's Address	City	State	Zip

Secondary Insurance		Patient is ☐ Policyholder ☐ Spouse ☐ Dependent
ID or Subscriber #	Group #	

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) (only complete if the patient is over age 18)

The purpose of the Notice of Privacy Practices is to describe to you how Ear, Nose & Throat Surgical Associates may use and disclose your protected health information, certain restrictions on the use and disclosure of your healthcare information and your rights regarding protected health information. Ear, Nose & Throat Surgical Associates will not make any unapproved disclosure of your PHI without your written authorization. I hereby agree to permit Ear, Nose & Throat Associates to disclose my medical and billing protected health information to the following: (Example: spouse, friend, relative, etc. This does not apply to other physicians, insurance carriers, or attorneys).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ **I do not authorize the release of my medical or billing information**

AUTHORIZATION & RELEASE

I certify the information on this form is accurate and complete to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay the bills at time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I also understand I am responsible for all second opinion and pre-admission review requirements. I acknowledge that Ear, Nose & Throat Surgical Associates has provided me a copy of their Privacy Practices.

Signature: _____ Date: _____