Century.Staff@CenturyENT.net

Century
ear · nose & throat

WELCOME TO OUR OFFICE

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/____ Gender: M F Other Marital status: S M D W

Race: _____ *Ethnicity*: _____ *or* Declined to Specify *Language* : _____

Email Address: _____

***Preferred Phone Number (please circle):* Home or Cell**

Home (____)_____-_____ Cell (____)_____-_____ Work (____)_____-_____

May we leave a message with health information (please circle): Yes or No

Emergency Contact Name:

Relationship to patient_____ Name:_____ Phone: (____)_____-_____

Authorization to Release Patient Health Information:

I authorize the following people to have full access to any and all of my medical information with Century ENT:

_____

_____

This authorization expires _____ **Signature** _____ **Date** _____

Insurance Information:

Primary Insurance Carrier

Name of Insured _____ DOB ____/____/____ HMO *or* PPO

Relationship to patient: Self Spouse Parent

Secondary Insurance Carrier

Name of Insured _____ DOB ____/____/____ HMO *or* PPO

Relationship to patient: Self Spouse Parent

Information for persons in charge of payments for patients under the age of 18 years

Last Name _____ First Name _____ Middle Initial _____

If different from Patient:

Address _____ City _____ State _____ Zip _____

DOB: ____/____/____ Gender: M F Phone # (___)_____-_____ Work # (___)____-_____

I read and understood the notice of privacy practice regarding my care: Initial: ____

I hereby certify that to the best of knowledge the information provided is true and accurate:

Patients signature or responsible guardian: _____ Date: _____

For office use only: Reviewed by: Date: