EAR NOSE THROAT ALLERGY CENTER
MARK WELCH, D.O., F.A.O.C.O.

PATIENT INFORMATION

PATIENT NAME				ALSO KNOWN AS/MAIDEN NAME	SOCIAL SECURITY NUMBER
DATE OF BIRTH	AGE	SEX M/F	LANGUAGE ENGLISH SPANISH	MARITAL STATUS MARRIED SINGLE DIVORCED LEGALLY SEPERATED WIDOWED LIFE PARTNER OTHER	
RACE ASIAN CAUCASIAN NATIVE AMERICAN AFRICAN AMERICAN HISPANIC OTHER				OTHER INFORMATION	
ADDRESS				CITY,STATE	ZIPCODE
TELEPHONE	PAGER/CELL			PRIMARY CARE PHYSICIAN	TELEPHONE
EMPLOYER	EMPLOYER ADDRESS			CITY,STATE	ZIPCODE
EMPLOYER TELEPHONE				EMAIL ADDRESS	

GUARANTOR INFORMATION

RELATIONSHIP TO PATIENT	GUARANTOR NAME	SOCIAL SECUITY	AGE	SEX M/F
ADDRESS		CITY,STATE	ZIP CODE	
TELEPHONE	PAGER/CELL	EMPLOYER		
EMPLOYER TELEPHONE				

EMERGENCY CONTACT

NAME	RELATIONSHIP	TELEPHONE	PAGER/CELL
TELEPHONE	PAGER/CELL	COMMENTS	
COMMENTS			

NEXT OF KIN

NAME	
TELEPHONE	PAGER/CELL
COMMENTS	

PRIMARY INSURANCE

INSURANCE COMPANY NAME			
ADDRESS			
CITY,STATE	ZIP CODE		
TELEPHONE NUMBER	EFFECTIVE DATE		
IDENTIFICATION NUMBER	GROUP		
PATIENTS RELATIONSHIP TO SUBSCRIBER			
SUBSCRIBER'S NAME			
SUBSCRIBER'S EMPLOYER			

SECONDARY INSURANCE

INSURANCE COMPANY NAME	
ADDRESS	
CITY,STATE	ZIP CODE
TELEPHONE NUMBER	EFFECTIVE DATE
IDENTIFICATION NUMBER	GROUP
PATIENTS RELATIONSHIP TO SUBSCRIBER	
SUBSCRIBER'S NAME	
SUBSCRIBER'S EMPLOYER	

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE- A detail of your rights and how your medical information will be used and disclosed by Ear Nose Throat and Allergy Center is set forth in the NOTICE OF PRIVACY ACTS. A copy has been furnished to me and is posted in the clinic.

I understand and agree that I am ultimately responsible for the balance on my account for any professional service rendered. Medicare rules and Ear Nose Throat and Allergy Center insurance agreements may affect patient responsiblilty for the account. I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify upon of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Ear Nose Throat and Allergy Center on my behalf for any unpaid services rendered by Ear Nose Throat and Allergy Center physicians.

I authorize the release of medical record information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits. The information authorized for release may include information about communicable or noncommunicable disease, mental health, substanse or alcohol abuse.

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES

Signature _____ Date _____