



**Orlando Ear, Nose & Throat Associates, P.A.**

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Ear, Nose & Throat**

REGISTRATION  
(PLEASE PRINT)

DATE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Primary or Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_

**PRIMARY INSURANCE**

Person Responsible for Account \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Description of Illness \_\_\_\_\_

**ADDITIONAL INSURANCE**

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I \_\_\_\_\_ (Name of Insured) hereby authorize \_\_\_\_\_ (Name of Insurance Company)

to pay and hereby assign directly to *Orlando Ear, Nose & Throat Associates, P.A.* all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to *Orlando Ear, Nose & Throat Associates, P.A.* will be credited to my account, in accordance with the above assignment. There will be a \$20.00 charge for returned checks.