

**Eastern Carolina ENT Associates, PA**  
**(919) 934-0948**

Date: \_\_\_\_\_

Patient Name : \_\_\_\_\_

Address : \_\_\_\_\_

City, State,  
Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Phone : \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ Secondary Ins: \_\_\_\_\_

*Please have your insurance card and one other ID available at our front desk.*

**SPOUSE**

Name : \_\_\_\_\_ SSN : \_\_\_\_\_

Employer : \_\_\_\_\_ Work Phone: \_\_\_\_\_

**GUARDIAN / PARENT INFORMATION IF PATIENT IS A MINOR**

Mother

Father

Name : \_\_\_\_\_

SSN : \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**CHECK-OUT NOTE**

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our patient relations dept prior to SURGERIES.

**RELEASE OF INFORMATION and ASSIGNMENTS OF BENEFITS DECLARATION**

I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE, BLUE CROSS/SHIELD Insurance for services rendered. I understand and agree to the above conditions.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

