CENTRAL FLORIDA ENT ASSOCIATES, P.A.

Thank you for choosing Central Florida ENT Associates, P.A. for your Ears, Nose, and Throat and Allergy needs. We are here to provide the highest quality of care, as friendly and efficiently as possible. With this in mind, please complete the following information sheet as thoroughly as possible. Please remember to write legibly and sign where we have indicated that a signature is required.

PATIENT INFORMATION (CONFIDENTIAL):

NAME (Last, First, MI): _____

DATE OF BIRTH: ____/____/_____ AGE: _____ SSN: _____-_____-_____ SEX: M ___ OR F ___

STREET ADDRESS: _____
Street City State Zip

MAILING ADDRESS (If different from street): _____
Street/PO Box City State Zip

PHONE (Circle Preference): HOME _____ WORK _____ CELL _____

EMAIL ADDRESS: _____

PREFERRED METHOD OF COMMUNICATION: _____

IS PATIENT: A MINOR ___ SINGLE ___ MARRIED ___ DIVORCED ___ OTHER ___

****We are required by the Federal Government to ask and collect information on race, ethnicity, employment status and language preferences. We appreciate you providing us with this information.****

Race: **__American Indian or Alaskan Native __Asian __Black or African American**
__Native Hawaiian or other Pacific Islander __White __Other __Refuse to Report

Ethnicity: **__Hispanic or Latino __Not Hispanic or Latino**

Language Preference: **__English __Other**

Employment Status: **__Employed __Not Employed __Retired**

EMPLOYMENT INFORMATION:

EMPLOYMENT STATUS: ___ EMPLOYED ___ NOT EMPLOYED ___ RETIRED

IF EMPLOYED, NAME OF EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY _____ ST____ ZIP_____

EMERGENCY CONTACT: _____ PHONE: _____ RELATION: _____

OTHER PROVIDER INFORMATION:

NAME & LOCATION OF REFERRING DR OR PCP: _____

OTHER DR(S) OR PERSON YOU ALLOW US TO RELEASE INFORMATION TO: _____

_____

PRIMARY PHARMACY: _____

IF PATIENT IS A MINOR (UNDER 18)

*****Parent/ Guardian Information form must also be completed**:***

YOUR NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS (If different from Patient): _____
Street/PO Box City State Zip

PHONE: HOME _____ WORK _____ CELL _____

YOUR DATE OF BIRTH: ____/____/_____ YOUR SSN: _____-_____-_____ SEX: M __ OR F ___

YOUR EMPLOYER: _____ WORK PHONE: _____

ARE YOU CURRENTLY A PATIENT IN OUR OFFICE? _____

INSURANCE INFORMATION:

Your insurance contract contains a coordination of benefits provision, which applies when you have more than one health insurance. There are specific laws that mandate the order of payment responsibility for covered services when an individual is covered by more than one health insurance. We are REQUIRED to identify situations where a health insurance plan payer may have paid benefits in error because another plan should have been the primary payer. We are REQUIRED to execute due diligence to ensure that our records accurately reflect your health care coverage information. Please answer the following questions…

1. Do you and/or a member of your family have other health insurance in addition to the primary insurance noted above?
____ Yes ____No **If yes, please complete the secondary insurer section below. **

2. Do you and/or a member of your family have Medicare coverage?
____ Yes ____No **If yes, AND you have a Medicare Supplement or secondary insurance, please complete the secondary insurer section below.**

3. Are you enrolled in Hospice?
____ Yes ____No **If yes, please list the Hospice Name, Address, and phone as the Primary Insurer**

4. Are the services to be provided the result of an accident or injury? ____ Yes ____No

PRIMARY INSURER:

Name of Insurance: _____ Is this through an Employer? Yes or No

Insured's Name: _____ DOB: _____

Insured's SSN: _____ Relation to Patient: _____

SECONDARY INSURER (if applicable):

Name of Insurance: _____ Is this through an Employer? Yes or No

Insured's Name: _____ DOB: _____

Insured's SSN: _____ Relation to Patient: _____