ENT Voice & Sinus Center of Nevada

Patient Name: Last First Middle Initial

Address: Home Phone Cell Phone

City: State Zip Work Phone Social Security #

Date of Birth: ☐Male ☐Female Email:

Ethnicity: ☐American Indian ☐Asian ☐African American ☐White ☐Hispanic/Latino ☐Not Hispanic Latino ☐Other

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Employer: Occupation:

Work Related Injury: ☐Yes ☐No Automobile Accident: ☐Yes ☐No Date of Injury/Accident:

Retired ☐Yes ☐No Advanced Directive ☐Yes ☐No Copy on File ☐Yes ☐No Referred by:

Emergency Contact: Relationship: Phone:

IF DIFFERENT FROM ABOVE- POLICY HOLDER/INSURED INFORMATION-Primary Insurance

Insured's Name: Last First Date of Birth

Address: Primary Phone

City: State Zip Patient Relationship Social Security #

Employer Name and Address:

Primary Insurance: Phone Number:

Group # Policy Number:

IF DIFFERENT FROM ABOVE- POLICY HOLDER/INSURED INFORMATION-Secondary Insurance

Insured's Name: Last First Date of Birth

Address: Primary Phone

City: State Zip Patient Relationship Social Security #

Employer Name and Address:

Primary Insurance: Phone Number:

Group # Policy Number:

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance accompany and I assign benefits to Susan Schwartz, DO, PC. We will gladly file your insurance claim, however, payment for copays and deductibles are required at the time of services are rendered. We cannot guarantee payment to Susan Schwartz, DO, PC. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for all amounts not covered payable to Susan Schwartz, DO, PC. Parents/Guardians are responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collection agency. A $75 fee will be charged for no-show appointments and appointments not cancelled 24 hours in advance. There is a $75 fee for all bad checks returned by the bank. **I authorize release of all medical records to referring and primary care physicians and the insurance company, is applicable. I authorize fax transmissions of medical records if necessary.**

Signature:_____ **Date:**_____