

## Nashville Ear, Nose, and Throat Specialists

Not filling out this form completely may delay or result in non-payment of insurance benefits thus leaving you responsible for services rendered.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex \_\_\_\_\_

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

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

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

Spouse or Legal Guardian: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Who referred you to our office? \_\_\_\_\_

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

Pharmacy Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Were you injured in an automobile accident? \_\_\_\_\_ Were you injured at work? \_\_\_\_\_

If yes: Billing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone#: \_\_\_\_\_

Contact Person: \_\_\_\_\_

### PRIMARY INSURANCE COMPANY

Name of Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy holder's SS#: \_\_\_\_\_ Policy Holders DOB: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

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

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

**SECONDARY INSURANCE COMPANY**

Name of Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy holder's SS#: \_\_\_\_\_ Policy Holders DOB: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Insurance Group #: \_\_\_\_\_

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

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

Does your insurance require a referral? \_\_\_\_\_ If yes, do you have a referral for today's visit? \_\_\_\_\_

\*\*\* If my insurance carrier requires a referral and one is not obtained, I understand I am responsible for payment of services rendered.

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

Assignment of Benefits: I certify that the information given by me is correct. I hereby authorize payment to Nashville Ear, Nose & Throat Specialists, PLLC of the insurance benefits payable to me. In applying for payment under Title XVIII or Title XIX of the Social Security Act, I request payment for authorized benefits be made on my behalf to those who accept assignment. I further understand that I am responsible for any charges not covered or payable by this assignment.

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

Authorization to Release Information: I hereby authorize any holder of medical information about me to release to my insurance carrier(s) or sponsoring agency(s) or to the Social Security Administration or its intermediaries or carriers, when relevant information requested by them and needed for processing of benefit claims.

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