
**Name** _____**Date of Birth** _____
**Age:** _____ **male / female**

**Address:** _____ **Apt #** _____
**City** _____ **State** _____ **Zip Code** _____ **SS#** _____
**Best Number to reach you:** _____ **Alternate #:** _____

**Marital status:** single married widowed other **Email:** _____

**Employer** _____ **Spouse** _____**DOB** _____
**Race:** White Black /African American American Indian Asian Other _____
**Ethnicity:** Non-Hispanic Hispanic **Primary Language :** English Spanish Other _____

**Insurance: Primary** _____ **Insured Person** _____
**Employer** _____**DOB** _____**SS#** _____
**Secondary** _____ **Insured Party**_____
**Employer** _____**DOB** _____ **SS#** _____

****only fill out if patient is a minor ****

**Parent ____ or Legal Guardian ____ ( please provide proper documents)**
**Mother** _____ **DOB** _____ **SS#** _____
**Father** _____ **DOB** _____ **SS#** _____

*****We prescribe medications electronically***Please provide pharmacy info*****

**Local Pharmacy**_____ **Phone** _____
**Address:(crossroad)**_____
**Mail Away Pharmacy** _____**Phone** _____
**Primary Care Doctor** _____**Phone**_____
**Referred by** _____

**Please note: It is the patient's responsibility for knowing their insurance benefits as well as, which lab, diagnostic center, hospital & surgical center, etc. Insurance benefits change and we cannot be responsible for any added fees you incur due to non-participating laboratories, facilities, etc. Please let the staff know if you need a specific facility or lab.**

**I understand that I am responsible for all co-insurance, deductibles & co-pays at the time services are rendered. I will pay by _____check _____cash _____ credit card If payment is not collected at the time of service, there will be a $25.00 charge added to your account each time. Arrangements need to be made with the front office manager or billing manager prior to being seen by the doctor.**

**Patient Privacy Authorization and release: I hereby authorize medical treatment by Richard B. Allen, M.D., Christopher L .Slack, M.D., Michele L. Richards, M.D., Charles J. Zeller, D.O. and Nicole M. Thompson, ARNP. I hereby authorize release of medical information acquired in the course of medical treatment to authorized parties for reasons of payment, medical treatment and referral to other medical facilities.**
**I hereby assign all medical /surgical benefits to Associated Coastal ENT Physicians PA. I understand that I am responsible for all charges whether or not said insurance pays.**
**We follow all HIPPA and HITECH Act guidelines, if there are particular circumstances that you need to specifically revoke access to your health record, please ask the receptionist for a special form, otherwise it will be assumed that the guidelines in place are agreeable to our patients.**

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**Patient Signature / Guardian Signature** **Date**