Date:

Greenville ENT

Patient
SSN _____ Date of Birth _____ Age _____ Sex
Primary Mailing Address _____

Race (Please Circle) White / American Indian / Asian / Black / Native Hawaiian / Other
Ethnicity (Please Circle) Hispanic Origin / Non-Hispanic origin / Decline Marital Status_____ Occupation _____
What doctor recommended you to see us? _____
Last Name First Name Practice Name Phone Number
Family Doctor _____
First Name Last Name Phone # Practice Name

Personal Day Phone #: _____ Alt Phone # _____ Email Address _____
Emergency Contact _____ Phone # _____
Last Name First Name Relationship

Pharmacy #1 _____ Pharmacy #2 _____

If Patient is A Minor:
Father's Name _____ Daytime Phone # _____ Alternate Phone # _____
Mother's Name _____ Daytime Phone # _____ Alternate Phone # _____
In the event that a parent cannot bring patient to an appointment, I give consent for Greenville ENT Associates to evaluate and treat patient in my absence under the supervision of _____ Relationship to patient : _____

If you would like anyone other than yourself to have access to your information, please list below.
Name _____ Relationship _____ Phone # _____
Other family members seen by our doctors: _____

Insurance Information

Primary Insurance Carrier _____
Sex _____ Policyholder's Birth Date _____
Subscriber ID# _____
Relationship to policyholder: Self Spouse Dependent Child Other
Policyholder's Name _____
Policyholder's SSN _____
Group # _____
Employer _____

Secondary Insurance Carrier _____
Sex _____ Policyholder's Birth Date _____
Subscriber ID# _____
Relationship to policyholder: Self Spouse Dependent Child Other
Policyholder's Name _____
Policyholder's SSN _____
Group # _____
Employer _____

Consent for Treatment, Payment, Healthcare Operations, and Acknowledgement of Receipt of Notice of Privacy Practices

I request that payment under the medical insurance program be made payable to Greenville ENT for services rendered. I understand that I am financially responsible for all charges incurred at Greenville ENT and agree to pay all charges not covered by my insurance. I authorize disclosure of my personal health information to carry out treatment, payment or health care operations. I agree that Greenville ENT may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purpose. I have received the Greenville ENT HIPAA privacy policy and Notice of Information Practices that provides a more complete description of information uses and disclosures. I also understand I have the right to request restrictions as to how my health information may be used or disclosed. I agree that Greenville ENT may contact me on any of the phone numbers listed above, via employee, auto-dialer, or text message (data rates may apply), related to appointment reminders, healthcare information, and billing matters. I have the right to revoke this consent in writing except to the extent that Greenville ENT has already taken action. I further permit a copy of the authorization to be used in place of the original.

Labs/Specimens: My insurance requires labs/specimens/cultures/etc. to be sent to: _____
(If left blank, labs will be sent to our preferred partners)

_____ _____ _____
Patient/Responsible Party (Print Name) Patient/Responsible Party Signature Date

_____ _____ _____
Responsible Party SSN Responsible Party DOB Relationship to Patient