1206 Cornelia Road
Anderson, SC 29621
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Web/ www.AndersonEarNoseThroat.com

IMPORTANT NOTICE

Due to HIPAA requirements, this form must be filled out completely. Please ask for help if you have questions about any field.
We will be unable to file insurance for incomplete forms. ~ Thank You.

PATIENT INFORMATION

Full Name:				Date of Birth:			Age:	
Social Security #:		Sex		Race:		Employment Status	Full Time Part Time Self Retired None Disabled	
Home Phone:		Cell Phone:		Work Phone:		Student Status:	Full Time Part Time None	
Mailing Address:						Employer School:		
City, State, Zip:						Address:		
Marital Status:	S M W D Sep	Emergency Contact/Phone		City, State, Zip				
Email Address				Referred by:				
How did you hear about us?								
Have you seen anyone else for these services? If so, whom?								

INSURANCE INFORMATION

	Primary	Secondary	Tertiary
Subscriber (Legal Name):			
Telephone:			
Relation to patient:			
Date of Birth:			
Social Security #:			
Employer:			
Address:			
City, State:			
Zip Code:			
Employer Phone:			
Insurance Company:			
Subscriber ID #:			
Group #:			
Patient ID (if different):			
Insurance Phone #:			

CONSENT TO TREAT, BENEFIT ASSIGNMENT AND RELEASE OF INFORMATION

- I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a physician, while such treatment is provided at Anderson ENT, PA. I certify that the insurance information listed above is correct and that all insurance benefits for services rendered are directly assigned to Anderson ENT, PA. Dole P. Baker, Jr., MD is an owner in both his practice and the Piedmont Surgery Center. I understand that I am financially responsible for all charges regardless of benefits. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance claim submissions and for all payments requiring a signature.
- Should this account be turned over to a collection agency for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

Signature: ____ **Date:** ____________________