PATEINT DEMOGRAPHIC UPDATE

In order to minimize errors in your patient record at this office, we require that the following information be updated on a yearly basis. Even if your information has not changed, we ask that you take a moment to complete the following:

PERSONAL INFORMATION

Patient Name: ______________________________ Date of Birth (D.O.B): ____________________

Address:____

City, State, ZIP code: ____

Home Phone: ________________________ Work Phone: ______________________________

Cell Phone: _________________________ FAX Number: _____________________________

E-Mail: ______________________________________

INSURANCE INFORMATION

______________________________	______________________________
PRIMARY INSURANCE COMPANY	SECONDARY / TERTIARY INSURANCE COMPANY
Name of Insured: ____________________	Name of Insured: ____________________
Relationship to Patient: ______________	Relationship to Patient: ______________
Insured's Birthdate: _________________	Insured's Birthdate: _________________

*Please Note: East Valley ENT is ONLY contracted with **Medicare, Blue Cross*, and Blue Shield*** at this time. All other insurance companies are considered Out-of-Network or Non-Preferred providers and the patient/responsible party may be responsible for a higher percentage of the bill than if treated by an In-Network or Preferred provider. (*PPO only. Certain plans may have restrictions – ask office staff for more info)*

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment, or examination rendered to me or my child during the period of such care to third party payors and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

X ____ DATE: ____________________

Signature of Patient (or parent/guardian, if the patient is a minor)