(LAST FIRST MIDDLE)

PATIENT NAME _____ SS# _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ HOME PHONE# _____ CELL# _____

MARITAL STATUS: S M D W SEX: M / F RACE: _____ AGE: _____ PRIMARY LANGUAGE _____ ETHNICITY _____

PATIENT'S EMPLOYER: _____ WORK# _____

SPOUSE'S NAME: _____ SPOUSE'S DATE OF BIRTH _____

SPOUSE'S EMPLOYER: _____ WORK# _____ SPOUSE'S SS# _____

WHO IS PERSON RESPONSIBLE FOR YOUR BILL? SELF OR OTHER

NAME OF PERSON RESPONSIBLE, IF OTHER: _____ RELATIONSHIP: _____

(NOTE: PARENT BRINGING CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF ACCOUNT)

IF PATIENT IS A MINOR (18 YEARS OR YOUNGER), PLEASE COMPLETE THE FOLLOWING INFORMATION:

FATHER'S NAME: _____ SS# _____

EMPLOYER: _____ WORK# _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT FROM ABOVE: _____

PHONE# IF DIFFERENT FROM ABOVE: _____

MOTHER'S NAME: _____ SS# _____

EMPLOYER: _____ WORK# _____ DATE OF BIRTH _____

ADDRESS IF DIFFERENT FROM ABOVE: _____

PHONE# IF DIFFERENT FROM ABOVE: _____

WHO CAN WE NOTIFY IN CASE OF AN EMERGENCY? (SOMEONE NOT LIVING IN SAME HOUSEHOLD)

NAME: _____ PHONE# _____ RELATIONSHIP: _____

IS YOUR VISIT RELATED TO AN ACCIDENT OR INJURY? YES OR NO

IF SO, HOW? _____ **DATE IT HAPPENED:** _____

WHO REFERRED YOU HERE? _____

WHO IS YOUR PRIMARY CARE DOCTOR? _____

Please circle all the ways that you approve for us to communicate with you:

Home phone, Work Phone, Cell Phone, Text, Email

Can we leave a message: Yes or No

E-mail Address _____

CONSENT FOR TREATMENT - RELEASE OF MEDICAL INFORMATION - FINANCIAL RESPONSIBILITY

I, the undersigned, do hereby consent to treatment necessary for the care of the above named patient. I hereby authorize the release of any or all medical records and/or financial records to the referring physicians or physicians referred to, my insurance carriers, or any corporation which is or may be under contract to Decatur ENT Associates, including but not limited to itemized statements of charges, insurance information, and patient/responsible party demographic information. I further acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to S. Kinney Copeland, M.D., George H. Godwin III, M.D., and/or Benjamin W. Light, M.D. In the event an account is not paid within 90 days from date of service, the undersigned agrees to pay all costs of collections including attorneys' fees and hereby waive all rights of exemption under the Constitution of the State of Alabama.

Date _____ Signed _____