Patient Chart #	PIEDMONT EAR, NOSE & THROAT ASSOCIATES	Staff Initials

PATIENT INFORMATION

Patient's Name: Last | First | Middle | Maiden

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth

Social Security Number

Gender ☐ Male ☐ Female

Race: ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Asian ☐ Other Pacific Islander ☐ Black or African American ☐ Undefined ☐ White or Caucasian ☐ Refuse to report ☐ More than one race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Undefined ☐ Refuse to report

Living Will: ☐ Yes ☐ No

Address: Street | City | State | Zip

Phone: Home ( ) Cell ( )

Preferred method of contact: ☐ Home ☐ Cell ☐ Work

Spouse's Name: Last | First | Middle

Spouse's Date of Birth:

Emergency Contact (not living with you): Name | Phone ( )

Primary Care Physician | Phone ( )

Referring Physician: | Phone ( )

Would you like to receive an invitation to setup your Follow My Health Patient Portal? ☐ Yes ☐ No

Email Address:

EMPLOYER INFORMATION (ADULT)

Patient's Employer | Occupation | Phone ( )

Spouse's Employer | Phone ( )

MINOR PATIENTS (Under 18)

Father's Full Name		Mother's Full Name	
Home Phone ( )	Cell Phone ( )	Home Phone ( )	Cell Phone ( )
Employer	Work Phone ( )	Employer	Work Phone ( )
Father's Date of Birth	Father's S.S. #	Mother's Date of Birth	Mother's S.S. #
If Parents are Separated/Divorced or Not Married ☐ Joint Custody ☐ Sole Custody ☐ Other		Name of Custodial Parent/Legal Guardian	

INSURANCE INFORMATION

Primary		Secondary/Supplemental/Tertiary	
Subscriber Name	Subscriber Date of Birth	Subscriber Name	Subcriber Date of Birth
Subscriber ID #	Group #	Subscriber ID #	Group #

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize direct payment of medical/surgical benefits to Piedmont Ear, Nose & Throat Associates for medical services received. I understand that health insurance is an agreement between me and my insurance company to pay a specified amount for medical care, and further acknowledge that my physician's fees are not based on the amount insurance will pay. I understand that I am financially responsible for any balance not paid by my insurance carrier, to include co-payments, co-insurance, deductibles and/or charges not covered by my insurance. I request payment of authorized Medicare/Medicaid benefits, if applicable, be made on my behalf for any services furnished to me by Piedmont Ear, Nose & Throat Associates. I authorize any holder of medical and other information about me to release to Medicare/Medicaid and its agents any information needed to determine these benefits for related services. I further authorize Piedmont Ear, Nose & Throat Associates to release or receive any medical or incidental information about me that may be necessary for either medical care or processing of insurance claims.

Signature of Patient or Responsible Party | Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received, or have been provided access to, a copy of Piedmont Ear, Nose & Throat Associates' Notice of Privacy Practices.

Signature of Patient or Responsible Party | Date