VALLEY EAR, NOSE, AND THROAT ASSOCIATES, P.C.

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Madison Surgery Center
460 Lanier Rd., Suite. 203
Madison, AL 35758
(256) 772-7148
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PATIENT INFORMATION

Patient Name: _____
Last First Middle

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ SS# _____ Driver's License # _____

Sex: M _____ F _____ Patient relationship to responsible party: Self _____ Spouse _____ Child _____ Other _____

Primary Care Physician: _____ Referred By: _____

Patient Employer: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____

Address: _____

Phone: _____ DOB: _____ SS#: _____

INSURANCE INFORMATION

Primary Ins. Co.: _____ Insured DOB: _____

Contract#: _____ Group#: _____

Secondary Ins. Co.: _____ Insured DOB: _____

Contract#: _____ Group#: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Other Insurance Company benefits be made to Valley Ear, Nose and Throat Associates, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand that the patient is responsible only for the deductible, coinsurance, and non-covered services. I requested that the above remain in effect until written notice is received from me.

Signature: _____ Date: _____