MANCHESTER EAR, NOSE & THROAT, LLC
WELCOME TO OUR PRACTICE

PATIENT #__________________ DATE_______________

Name____
Last First MI

Address____

City____State_________Zip_____________

Date of Birth________________ Age________ M__F__ Marital Status__________

Home Phone #_______________Cell #_________________Work #________________

Name of spouse, parent or contact person_____________________________________

Release of medical information may be given to________________________________

Family Doctor_______________________________ Referred By___________________

Student Full Time___________________________ Part Time_____________________

Employed Full Time_______ Part Time_______ Retired_______ Unemployed______

Name of Employer____

NOTIFICATION REQUIRED BY THE FEDERAL GOVERNMENT

Privacy Notification and Insurance Authorization
I authorize routine release of my medical information for purposes of treatment, billing and routing health care operations. I understand that my medical information will not be released for any other purpose without my consent. I request that payment of authorized healthcare benefits be made to the providers of Manchester Ear, Nose & Throat Center, LLC. I authorize any medical information about me to be released to my health insurance agency any information needed to determine the benefits payable for related services. **I am aware that I am responsible to understand my individual insurance benefits and that I am liable for any non-covered services.**

Signature:____ Date:____________