Appointment with: Dr. ☐Sporck ☐Lough ☐Nichols ☐Dawson ☐Goins ☐Beasley ☐Phillips ☐Cunningham, NP

EN&T Assoc. of Charleston, Inc.

Please complete this form in its entirety and return in the envelope provided at least 5 days prior to your scheduled appointment.

PATIENT INFORMATION FORM

Preferred Pharmacy:

Patient's Name:	Birthdate:
Street Address:	Sex: ☐ Male ☐ Female
City/State/ZIP:	Social Security #
Occupation:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Child
Employer: Work Phone:	Home Phone: Cell Phone:
E-Mail:	

Primary Care Physician:	Referred by:

If patient is married, spouse's information is required.	***In case of emergency contact:***
Spouse's Name:	Name:
Birthdate: SSN:	Birthdate: SSN:
Employer:	Relationship:
Phone: Home Work Cell	Phone: Home Work Cell

If patient is a minor child, please complete this section. **Are parents married to each other?** ☐ **Yes** ☐ **No**

FATHER	**MOTHER**
Name:	Name:
Street Address	Street Address:
City/State/ZIP	City/State/ZIP
Birthdate: SSN	Birthdate: SSN
Employer:	Employer:
Phone: Home Work Cell	Phone: Home Work Cell

If parents are divorced and the non-custodial parent has health insurance coverage on the patient, that parent's signature is required on the BACK OF THIS FORM in order to bill the insurance.

Current insurance information is required. Bring your insurance card(s) with you to the appointment. Adult photo identification (i.e. driver's license) is required for all patients.

PRIMARY COVERAGE - Effective Date:	**SECONDARY COVERAGE - Effective Date:**
InsuranceCo:	Insurance Co:
Cardholder's Name: Birthdate:	Cardholder's Name: Birthdate:
Relationship to Patient:	Relationship to Patient:
Policy ID: Group #:	Policy ID: Group #:
Social Security # of Insured:	Social Security # of Insured:
Insured's Signature:	Insured's Signature:

304 342-0124 ***Appointments:*** **304 340-2200**

Street Address: Medical Office Building North, St. Francis Hospital, Suite 200, 500 Donnally St., Charleston, WV 25301

Patient/Child's Name_____ Birthdate _____

Authorization to Bill Insurance

I, _____, hereby give my consent for Ear, Nose & Throat Associates of Charleston, Inc. to bill my insurance for services rendered to my child by a provider at Ear, Nose & Throat Associates of Charleston, Inc.

Authorization to release medical information to insurance carrier

I also hereby give my consent for Ear, Nose & Throat Associates of Charleston, Inc. to release medical and other relevant information to my insurance carrier as required by my insurance to process medical billings.

_____ _____

Insured Parent Date