ENT & SLEEP SPECIALISTS

Kanu Patel, MD | Scott Walen, MD | Rodrigo Martinez, MD | Adam Singleton, MD | Shama Shaikh, PA | Eileen Chai, PA

Last Name: _____ Middle Initial: _____ First Name: _____

Guardian Name: (If under 18) _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

E-Mail Address: _____ Birth Date: _____

Referring Physician: _____ PCP: _____

Primary Insurance Carrier: _____ Social Security # _____

Secondary Insurance Carrier: _____ Subscribers Name _____

Patient Relationship to Insured: Self Spouse Child Other Birth Date of Insured: _____

How did you hear about us? _____ If Referral or Other, Please Specify: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS AND AUTHORIZATION

☐ I have read and understand Notice of Privacy Practices and Billing Procedures for ENT & Sleep Specialists

☐ I herby assign my insurance benefits to be paid directly to the healthcare provider

☐ I authorize ENT & Sleep Specialists to release medical information required to process my claim

☐ I authorize ENT & Sleep Specialists to obtain/have access to my medication history

☐ I authorize my provider's office to contact me by mobile phone

Signature: _____ Date: _____