CLEVELAND EAR NOSE THROAT INC.

Patient Name _____ Date _____

Birthdate_____/_____/_____ Social Security # _____/_____/_____ Sex: M☐ F☐

Address_____ Apt._____

City_____ State_____ Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____

Patient's Employer_____ Work Phone (___)_____

Email Address _____

Other than yourself, with whom may we discuss your medical care, condition, or treatment?

Name _____Relationship_____ Phone # _____

May we leave a message at your home with other residents? ____ Yes ____ No

On your answering machine/voice mail? ____ Yes ____ No

INSURANCE INFORMATION – Please provide card(s) so that we can make a copy for your file

Insurance Company _____ **(PRIMARY)**

Policy Holder's Name_____ Policy Holder Birthdate _____

Member ID # _____Group# _____

Insurance Company _____ **(SECONDARY)**

Policy Holder's Name_____ Policy Holder Birthdate _____

Member ID # _____Group# _____

I hereby authorize Cleveland Ear Nose Throat Inc., a private practice, to obtain my medical and insurance information from the Cleveland Clinic Health System computer database.

XXX _____ Date: _____