

**ASSOCIATED COASTAL ENT
EAR, NOSE, THROAT & FACIAL SURGERY**

**RICHARD B. ALLEN, M.D.
MICHELE L. RICHARDS, M.D
CHRISTOPHER L. SLACK, M.D**

PATIENT INFORMATION

Patient Name _____ Date of Birth _____
Age ___ Sex ____
Address _____ Apt# _____
City _____ State _____ Zip _____
Phone:
Home _____ Daytime _____ Mobile _____
Social Security _____
Marital Status: Married Single Divorced Widowed
Employer _____ Work Phone _____
Position _____
Address _____
Referred by _____

PARENT/GUARDIAN INFORMATION (IF PATIENT IS A CHILD)

FATHER _____
SS # _____ DOB _____
Phone: Home _____ Daytime _____ Mobile _____
Employer _____
MOTHER _____
SS # _____ DOB _____
Phone: Home _____ Daytime _____ Mobile _____
Employer _____

SPOUSE INFORMATION

Name _____ DOB _____
SS # _____
Employer _____ Work Phone _____
Mobile _____

NEAREST RELATIVE (not living with you)

INSURANCE INFORMATION

Primary Ins _____ **Policy #** _____
Person Insured _____ **Group #** _____
SS # _____ **DOB** _____
Employer _____

Secondary Ins _____ **Policy #** _____
Person Insured _____ **Group #** _____
SS # _____ **DOB** _____
Employer _____

MEDICAL AUTHORIZATION: I hereby authorize medical treatment of the above named individual by Richard B. Allen, M.D., Christopher L. Slack, M.D. or Michele L. Richards, M.D.. I hereby authorize release of any medical information acquired in the course of my treatment to authorize parties requesting said information. I hereby assign all medical and/or all surgical benefits, to include major medical benefits to which I am entitle, including Medicare, private insurance and all other health care plans to Richard B. Allen, M.D., Christopher L. Slack, M.D. or Michele L. Richards, M.D.. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize releases of said information to secure payment. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL CO-PAYS, CO-INSURANCE AMOUNTS AND DEDUCTIBLES AT THE TIME OF EACH VISIT. IF ARRANGEMENTS NEED TO BE MADE FOR PAYMENT, YOU NEED TO DO SO PRIOR TO BEING SEEN. FOR YOUR CONVENIENCE WE ACCEPT: VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH AND CHECKS.

I WILL BE PAYING BY: _____ **CHECK** _____ **CASH** _____
CREDIT CARD

Patient/Guardian Signature
Date