Currens Lane Melvin
Moore Rheney Roberts
Seal Audio

Asheville Ear Nose & Throat
Patient Profile

ID #: _____
(For office use only)

PATIENT INFORMATION

Legal Name: _____
First Middle Last

Preferred Name: _____ DOB: _____/_____/_____ Sex: M F SSN: _____-_____-_____

Mailing Address: _____
City State Zip

Physical Address: _____
City State Zip

Preferred Contact #: _____ Cell / Home Alt Phone #: _____ Cell / Home / Work

I wish to receive my appointment reminders via (only circle one): PHONE TEXT E-MAIL

I authorize AHNE to leave messages on answering machine/voicemail of phone numbers listed above: YES NO

Employer: _____ Retired Unemployed Student Child

Marital Status: Married/Single/Divorced/Widow Language: _____ Race: _____ Ethnicity: _____

Email address: _____ *this will be used for the patient portal*

Emergency Contact: _____ Relationship to pt: _____

Emergency Contact Phone number: _____ ☐My emergency contact is also an *authorized designee*

AUTHORIZED DESIGNEE(S)*****If there are additional authorized designees, please ask for additional form***

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

PERSON RESPONSIBLE FOR PATIENT'S ACCOUNT (i.e. Guarantor, Parent, Guardian, etc.)

Legal Name: _____
First Middle Last

Relationship to patient: _____ DOB: _____/_____/_____ Sex: M F SSN: _____-_____-_____

Mailing Address: _____
City State Zip

Contact phone number: _____Cell/Home Alt phone number: _____Cell/Home/Work

Employer: _____ Retired Unemployed

PRIMARY INSURANCE

Subscriber's Name: _____
First Middle Last

Relationship to patient: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Insurance Company: _____ Employer: _____

SECONDARY INSURANCE *****Please list other insurance coverage on the back of this form***

Subscriber's Name: _____
First Middle Last

Relationship to patient: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Insurance Company: _____ Employer: _____