NORTH SHORE ENT
EAR, NOSE & THROAT ASSOCIATES

North Shore
AUDIO-VESTIBULAR LAB
The Art of Hearing — The Science of Balance

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PATIENT INFORMATION

Name of Patient _____ Age _____ Date of Birth ____/____/_____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sex ☐ M ☐ F Weight _____

Address _____ Driver's License No. _____ State _____

City _____ Social Security No. _____

State _____ Zip _____ Patient Occupation _____

Telephone: Home (____) _____ Employer Name _____

Work (____) _____ Address _____

Cell (____) _____ City _____ State _____ Zip _____

Spouse _____

Emergency Contact: (who does not live with you) Name _____ Telephone (____) _____

If patient is a minor, please complete this section

Name of Responsible Party _____

Address _____

City _____ State _____ Zip _____

Mother's Work Telephone (____) _____ Father's Work Telephone (____) _____

Mother's Name _____ Father's Name _____

Address _____ Address _____

City _____ State ____ Zip _____ City _____ State ____ Zip _____

If parents are divorced, who has legal custody? ☐ Mother ☐ Father ☐ Both ☐ Other

Responsible Party (if other than patient)

Name _____ Social Security No. _____

Address _____ Driver's License No. _____

City _____ State ____ Zip _____ Employer _____ Phone _____

Telephone Home (____) _____ Address _____

Telephone Work (____) _____ City _____ State ____ Zip _____

Family Doctor _____ **Referred by:** _____

Address _____ **Address** _____

City _____ **State** ____ **Zip** _____ **City** _____ **State** ____ **Zip** _____

Telephone (____) _____ **Telephone (____)** _____

INSURANCE INFORMATION

Records Release
This must be signed if any insurance is to be filed by you or us.

I hereby authorize North Shore Ear, Nose, & Throat Associates and/or North Shore Audio-Vestibular Lab to release to my insurance company any information acquired in the course of my examination or treatment.

Signed _____ **Date** _____

Assignment of Benefits
This must be signed if we are filing to your insurance company for payment

I authorize my insurance company to pay my medical benefits to North Shore Ear, Nose, & Throat Associates and/or North Shore Audio-Vestibular Lab for services rendered. I understand that I am responsible for any unpaid balance.

Signed _____ **Date** _____

Insurance Waiver
This must be signed by, or on behalf of, all patients

I understand that services provided to me may not be a covered benefit as defined by my insurance company. I agree to be personally responsible for payment for the services rendered. I also agree to pay any co-pays and/or deductibles as required by my insurance company.

Signed _____ **Date** _____

Notice of Privacy Practices
This must be signed by, or on behalf of, all patients

I have been given the opportunity to read and receive a copy of the Notice of Privacy Practices (NPP) of North Shore Ear, Nose, & Throat Associates and North Shore Audio-Vestibular Lab. The NPP provides detailed information about how the practice may use and disclose my confidential information.

The provider reserves the right to change the privacy practices that are described in the NPP. I understand that a copy of any Revised Notice will be provided to me or made available in the office.

Signed _____ **Date** _____

Primary Insurance Information

Subscriber's Name _____	Employer _____
Social Security Number _____	Address _____
Date of Birth _____	City _____ State ____ Zip _____
Insurance Co. _____	Telephone ( ) _____

Do you have secondary insurance? □ Yes □ No

If yes, the receptionist needs information regarding your secondary insurance so that your claim can be submitted appropriately.