Naugatuck Valley Ear Nose & Throat Associates, LLC

Personal Information

Email: ______________________

Today's Date:] ____________ Account #: ____________ SSN: ____________

First Name: ____________ MI: ______ Last Name: ____________

Address: ______________________________

Zip Code: ________ City: ____________ State: ____________

Date of Birth: ____________ Age: ______ Marital Status: ____________

Sex: ________ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (number you wish to be reached at) ____________ Other #: ____________

Occupation: ____________ Work No: ____________

Employer: ____________ Full Time Student: ☐ Yes ☐ No

In the event of an emergency please contact:

Name: ____________ Relationship: ____________ Phone No: ____________

Minor Name of Parent/Guardian ____________

Primary Care Physician: ______________________________

Referring Physician's Name: ____________ Phone No: ____________

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: ____________ Insured's Name: ____________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ____________ Group#: ____________

Employer: ____________ SSN: ____________ DOB: ____________

Secondary Insurance: ____________ Insured's Name: ____________

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: ____________ Group #: ____________

Employer: ____________ SSN: ____________ DOB: ____________

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: ____________ **Date:** ____________