Diseases of the Ears, Nose and Throat, Inc.

Patient Information

Doctor you are seeing today: ☐ **Timothy Nash, D.O.** ☐ **Timothy Drankwalter, D.O.** ☐ **Audiology**

Name: First______________________________ **Last**______________________________ **MI**______

Date of Birth:__________________ **Age:** ________ **Sex:** M/F **Social Security Number:**___________________________

Marital Status: Single/ Married/ Divorced/ Widowed (please circle one)

Race: ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Check box if patient declined
☐ Asian ☐ White
☐ Black/African American ☐ Other Race ________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Check box if patient declined

Email:____

Street Address:____

City/State/Zip: ____

Place of Employment: ____

Spouse: ____

Please check one box to indicate preferred number

☐ Home Phone ________________

☐ Cell Phone ________________

☐ Work Phone ________________

If patient is a child, both parents' names: ____

Emergency Contact:____________________________ **Phone:** ______________________ **Relationship:** _______________

Family Doctor: ____

Insurance Information

Insurance Company: ____ **Subscriber Name:** __________________________

If patient is not the subscriber, complete below:

Subscriber's relationship to patient _______________________ **SSN:** _______________________ **DOB:** ________________

Subscriber's place of employment: ____

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, OR ITS INTERMEDIARIES OR CARRIERS, OR MY PRIVATE INSURANCE CARRIER ANY INFORMATION NEEDED FOR THIS OR A RELATED CLAIM. I PERMIT A COPY OF THE AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE THE DOCTOR TO BILL ALL SERVICES AND ALLOW MY INSURANCE CARRIER TO ISSUE INDEMNITY PAYMENTS DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT ANY SERVICES NOT COVERED BY INSURANCE ARE THE OBLIGATION OF THE RESPONSIBLE PARTY.

____ ___________________________

SIGNATURE OF PATIENT, PERSONAL REPRESENTATIVE, PARENT OR GUARDIAN (IF PATIENT IS MINOR) **DATE**