



City ENT PLLC

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New York, NY 10065
(212) 832-0444
Fax: (212) 832-0009

PATIENT INSURANCE FORM

Name: _____ Date of Birth ____/____/____
Gender (check one) Male _____ Female _____ Marital Status (check one) Single _____ Married _____

Home Address _____ SSN _____
Home Phone# _____
City _____ State _____ Zip _____ Cell Phone# _____
Email _____

Employer: _____ Work# _____
Occupation _____

Policy Holder's Name: _____ SSN _____
Phone number _____ Date of Birth ____/____/____
Relationship to Patient _____

Primary Insurance: _____ Secondary Insurance: _____
Address _____ Address _____
Phone# _____ Phone# _____
Policy ID# _____ Policy ID# _____
Group# _____ Group# _____
Policy Holder _____

Referred by: _____

Primary Physician: _____
Address _____ City _____ State _____ Zip _____
Phone# _____ Fax# _____

Primary Pharmacy: _____ Phone number: _____ Zip _____

Emergency Contact: _____ Phone# _____
Address _____ City _____ State _____ Zip _____

Please remember that insurance is considered a method of reimbursing the patient for the fees paid to the doctor and is not a substitute for payment. If the doctor participates in your insurance plan, the patient is required to pay all the applicable co-payments at the time of visit. In the event that the account is turned over for collection, the collection fee and/or legal fees shall be your responsibility.

I understand that I am financially responsible for any amount not covered by the contract.

I hereby assign all the medical and/or surgical benefits, including major medical benefits, Medicare. Private insurance and other health plans, to the treating physician listed above. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment to be considered as valid as an original. I hereby authorize the release of all information necessary to the necessary Healthcare Facility Administration and others in order to secure payment.

Date: _____ Signature: _____