Arizona ENT Physicians PLLC

Ralph E. Bassett, MD FRCS(C)

PLEASE PRINT CLEARLY
PLEASE COMPLETE ALL ITEMS

Patient Name (last, first, middle initial): _____

Age: ____ Date of Birth: _____ Social Security: _____ Sex: ____ Marital Status: _____

Responsible Party (i.e. parent / spouse): _____

Date of Birth: _____ Social Security: _____ Sex: ____ Marital Status: _____

Local Address number / street _____

city,state,zip _____

Permanent Address number / street _____

city,state,zip _____

Local Phone Number _____ Alternate / Cell _____

Email address: _____

Referring Physician Name: _____

Primary Care Physician Name: _____

Do you want our office to send a letter summarizing your visit to the doctor(s)? [ ] YES [ ] NO

PATIENT'S INFORMATION:

[ ] Retired [ ] Full time student

[ ] Unemployed [ ] Part time student

Employer: _____

Address: _____

Phone: _____

Date of Birth: _____

Social Security: _____

RESPONSIBLE PARTY INFORMATION:

[ ] Retired [ ] Full time student

[ ] Unemployed [ ] Part time student

Employer: _____

Address: _____

Phone: _____

Date of Birth: _____

Social Security: _____

PRIMARY INSURANCE:

Name of Company: _____

Policy Holder Name: _____

Relationship: [ ] self [ ] spouse [ ] child

Certificate Number: _____

Group Number: _____

Effective Date: _____

Do you need a referral? [ ] YES [ ] NO

Do you have a co-pay? [ ] NO $ _____

SECONDARY INSURANCE:

Name of Company: _____

Policy Holder Name: _____

Relationship: [ ] self [ ] spouse [ ] child

Certificate Number: _____

Group Number: _____

Effective Date: _____

Do you need a referral? [ ] YES [ ] NO

Do you have a co-pay? [ ] NO $ _____

I UNDERSTANDTHAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY. I ASSIGN PAYMENT OF BENEFITS DIRECTLY TO PHYSICIAN.

I authorize release of any medical information necessary to process this claim. This authorization remains in effect until revoked by me in writing.

Patient's or Authorized Person's Signature: _____ Date of Signature: _____