

MOUNTAIN EAR, NOSE & THROAT ASSOCIATES, P.A.
SALYER HEARING CENTER

40 MITCHELL ROAD • SYLVA, NC
28779 166 HOLLY SPRINGS PARK
DRIVE • FRANKLIN, NC 28734 75
MEDICAL PARK LANE, SUITE B •
MURPHY, NC 28906

Any information obtained in these forms will be kept confidential according to HIPAA Standards!

Patient's Name _____
Last First Middle Name you go by)

Patient's Social Security No. _____ Date of Birth _____ Age _____ Sex _____

Address _____ Home Phone Number _____

City _____ State _____ Zip _____ Employer _____ Employer Phone No _____

Spouse (if married) _____ Spouse's Employer _____ Employer Phone No _____

If patient is a minor, please list Mother's Name _____ Father's Name _____

Name of Policy Holder _____ Relationship to Patient _____	
Social Security # of Policy Holder _____ Date of Birth _____	
Employer _____ Employer Phone No. _____	
[We will make a copy of all of your insurance cards]	
Primary Insurance Company _____	ID Number _____
Secondary Insurance Company _____	ID Number _____
Tertiary Insurance Company _____	ID Number _____

What physician requested this visit? _____ Family Physician _____

Please list Allergies to Medicines _____

IN EMERGENCY, CONTACT _____ RELATIONSHIP _____ PhoneNo. _____

Reason for today's appointment _____

What pharmacy do you use? _____ Pharmacy Phone No _____

Assignment of Insurance and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Mountain Ear Nose & Throat Associates, P. A. and/or Salyer Hearing Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all Protected Health Information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____