HUNTINGTON EAR NOSE THROAT
HEAD & NECK SPECIALISTS

Today's Date:	Referring Doctor:	Primary Doctor:	
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss	Last Name, First Name:	Marital Status:	Primary Language:
Street Address:		Date of Birth: Age: Sex:	
City, State, Zip Code:		Preferred Communication Method: CIRCLE ONE HOME CELL EMAIL	
Home Phone:	Cell Phone:	Email: @	
Occupation:			
Race:	Ethnicity:		
Preferred Pharmacy: Name: Phone #:	Pharmacy Location:		

INSURANCE INFORMATION

Insurance:	Person Responsible for Bill:		
Policy #:	Group #:	Insured Employer:	
Subscriber's Name:	Date of Birth:	Patient's Relationship to Subscriber: CIRCLE ONE Self Spouse Child Other	
Name of Secondary Insurance (if applicable):	Subscriber's Name:	Policy #:	Group #:

IN CASE OF EMERGENCY

Contact Name:	Relationship to Patient:	Home Phone #: Cell Phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Steven A. Battaglia, M.D. INC. dba Huntington Ear Nose Throat / Head & Neck Specialists or my insurance company to release any information required to process my claims.

_____ _____

Patient/ Parent/ Guardian Signature **Date**