Lake Norman
Ears, Nose & Throat
Piedmont HealthCare

Patient Information Sheet

Patient Name:(First)________________ (Last)________________ (Middle)________________

DATE OF BIRTH:________________ Email Address:(Optional)________________
Patient Address: ________________ Home Telephone #:________________
Home Address:________________ Cell #:________________
City:________________ State:________ Zip Code:________ Emergency Number #:________________
Emergency Name/Relation:________________ Social Security#:________________
Sex (Circle one): **Male** **Female** **Marital Status** (Circle one): **Married** **Single** **Other**
Primary Care Physician: ________________ Referring Physician: ________________
Patient's Employer: ________________ Employer's Phone Number: ________________
Employers Address: ________________
How were you referred to this office?________________
List any relatives that are patients here:________________

Responsible Party's Name:(if under age 18)________________ Relation to Patient:________________
Security Number:________________ Sex: M / F Birth Date:________________
Responsible Party's Address: ________________ Responsible Party's Phone #:________________
City:________________ State:________________ Zip Code:________________
Responsible Party's Employer:________________ Employer's Phone#: ________________
Employer's Address: ________________

Primary Insurance:________________ Patient's Relationship to Insured:________________
Are you the primary insured for your policy? Y / N **IF NO,** Insured's Name:________________
Insured's Name:________________ Insured's DOB:________________
Address: ________________ Insured's Sex: Male Female
City: ________________ State:________ Zip Code:________ Insured's SSN: ________________
Insured's Employer:________________ Employer's Phone:________________
Employer's Address:________________ City:________________ ST:________ Zip Code:________

Secondary Insurance:________________ Patient's Relationship to Insured:________________
Are you the primary insured for your policy? Y / N **IF NO,** Insured's Name:________________
Insured's Name:________________ Insured's DOB:________________
Address: ________________ Insured's Sex: Male Female
City: ________________ State:________ Zip Code:________ Insured's SSN: ________________
Insured's Employer:________________ Employer's Phone:________________
Employer's Address:________________ City:________________ ST:________ Zip Code:________

Please inform us if you have a third insurance________________

I hereby authorize Piedmont HealthCare to release information concerning my medical or surgical treatment to any insurance carrier, including Medicare and Medicaid. I further authorize payment being made directly to Piedmont HealthCare for my insurance benefits including major medical insurance. I understand that I am financially responsible to Piedmont HealthCare for my charges and that the filing of insurance does not relieve me of this obligation. I further authorize any payment made by insurance companies that are incorrect to be refunded to the insurance company. I consent to x-ray examinations, laboratory procedures and other medical treatment as recommended by my physician as provided by authorized personnel of Piedmont HealthCare. I also understand that Piedmont HealthCare is not responsible for any of my personal or valuable items I bring with me.

Signature (seal) ________________ Date: ________________
Information Verified by: ________________ Date: ________________