Nevada ENT & Hearing Associates
9770 S. McCarran Blvd.
Reno, NV 89523

PLEASE PRINT
Date:_____

Last Name	First Name	M.I	Date of Birth

Street Address	Apt#	City	State	Zip Code

Mailing Address (if different than above)	City	State	Zip Code

Home Telephone Number	Cell Phone Number	Work Telephone Number

Social Security Number	Gender (Male/Female)	Occupation

Responsible Party (if patient under 18)	Responsible Party SS#	Responsible Party DOB

Responsible Party relationship to Patient	Mother's Name	Father's Name

Referring Physician if Any	Family Physician

Person to contact in case of emergency	Phone Number(s)	Relationship to Patient

***** IN ORDER FOR US TO FILE A CLAIM WITH YOUR INSURANCE COMPANY, YOU MUST COMPLETELY FILL OUT ALL INSURANCE INFORMATION. YOUR INSURANCE COMPANY REQUIRES THAT WE HAVE THIS INFORMATION *****

PRIMARY INSURANCE

Insurance Company Name	Insurance Company Address

ID Number	Group Name/Number	Employer

Insured's Name	Relationship to Patient	Insured Social Security Number	Insured DOB

SECONDARY INSURANCE

Insurance Company Name	Insurance Company Address

ID Number	Group Name/Number	Employer

Insured's Name	Relationship to Patient	Insured Social Security Number	Insured DOB

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Nevada ENT & Hearing Associates, LLC, to request/disclose a copy of the specific health and medical information described below regarding:

Name of Patient: _____date of birth:_____

consisting of items such as; clinical notes, prescriptions, lab results, xray results,
(please note if the family or friends listed below are able to bring in the patient w/o your presence)

etc:_____

_____

Names of family or friends who can call and check on your well being and/or who can pick-up prescriptions, records, etc. when you are unable to:

Name: _____ Phone: _____ Relationship to patient_____

Name:_____ Phone: _____ Relationship to patient_____

For the purpose of Medical Care:

We are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization
- You may inspect a copy of the protected health information to be used or disclosed
- You may refuse to sign this Authorization
- We will provide you with a copy of the signed authorization, if requested.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of Patient: _____ Date:_____

Signature of Guardian:_____ Date:_____