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.

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Patient/ Parent/ Guardian Signature **Date**