

**Ear,
Nose &
Throat Specialist
Mark Aferzon, M.D., F.A.C.S.
Tel: (203)-954-0019 Fax: (203)-954-0018**

PATIENT'S
NAME _____ DATE OF BIRTH ___/___/___
ADDRESS _____ CITY _____ STATE ___ ZIP _____
HOME PHONE _____ EMPLOYER _____
BUS PHONE ___ - ___ - ___ SS# ___ - ___ - ___ MARITAL STATUS: M ___ S ___ W ___ D ___

SPOUSE OR RESP. PARTY _____
SPOUSE EMPLOYER _____ BUS PHONE ___ - ___ - ___
SPOUSE DATE OF BIRTH ___/___/___ SPOUSE SS# ___ - ___ - ___

REFERRING PHYSICIAN'S NAME _____
FAMILY PHYSICIAN'S NAME _____
EMERGENCY CONTACT OTHER THAN SPOUSE _____
RELATIONSHIP _____ PHONE ___ - ___ - ___

INSURANCE COVERAGE INFORMATION

MEDICARE ___ MEDICAID ___ HEALTH NET ___ BC/BS ___ CIGNA ___ CHN ___
US HEALTHCARE ___ AETNA ___ OXFORD ___ CT CARE ___ OTHER _____
ID# _____ INSURED NAME _____
SECONDARY INS. _____ ID# _____
INSURED NAME _____

Authorization of benefits to physicians/release information statement of responsibility.

I hereby authorize payment of insurance benefits covering medical charges directly to physicians of Mark Aferzon, M.D., L.L.C. In the event that it is necessary to retain an attorney for collection of any unpaid balance, I agree to pay reasonable attorney fees and other collection costs. I also agree to pay interest of 1 ¼ % per month on any unpaid balance not paid within 90 days of rendered service.

SIGNATURE OF RESPONSIBLE PARTY _____

I hereby authorize Dr. Aferzon & Staff to call my home and leave any and all messages with regard to my upcoming appointments or related issues. **SIGNATURE OF RESPONSIBLE PARTY** _____