Ear, Nose & Throat Specialist

Mark Aferzon, MD, FACS
Tel: (203)-954-0019 Fax: (203)-954-0018

PATIENTS
NAME____________________________________DATE OF BIRTH___/____/_____

ADDRESS____________________________CITY__________STATE____ZIP__________

HOME PHONE______________________ CELL 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 PHYSICIANS NAME_____________________________________

FAMILY PHYSICIANS 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 the office of Mark Aferzon, MD LLC. I take full responsibility for any and all co-pays, deductibles, co-insurance balances not covered by my insurance company. I understand that it is my sole responsibility to know my insurance benefits and all covered and not covered expenses.
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**___________________