

**Alliance ENT & Hearing Center**  
**Paul Christu, MD, Frederick Godley, MD, Anjali Mehta, MD, Jacqueline Joubert, RNP**  
**Susan Dey-Sigman, AuD, June DiMatteo, AuD, Sara Carnevale Fearon, AuD**  
**845 North Main Street Providence, RI 02904**

DATE: \_\_\_\_\_

CONSULT REQUESTED BY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**PATIENT INFORMATION:**

NAME: \_\_\_\_\_ DATE of BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

S. S. NUMBER: \_\_\_\_\_ SEX: \_\_\_\_\_ MARITAL STATUS: M S W D

ADDRESS: \_\_\_\_\_

(If college student please give current address and home address)

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ IF MINOR, PARENT/GUARDIAN NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

(If minor, parent/guardian employer)

ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT: NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY INSURANCE NAME: \_\_\_\_\_ POLICY #: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

SECONDARY INSURANCE NAME: \_\_\_\_\_ POLICY #: \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

AUTHORIZATION #: \_\_\_\_\_

(If Required)

**WORKER'S COMPENSATION: Alliance ENT & Hearing Center does not accept Worker's Compensation Insurance. We do not participate with work related injuries and claims.**

---

I hereby authorize Alliance ENT & Hearing Center to furnish information to insurance carriers concerning my illness and treatment, and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance and after sixty (60) days if no payment has been received by this office, full payment is due and payable by me.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE PATIENTS MUST SIGN BELOW**

I request that payment of authorized Medicare benefits be made whether to me or on my behalf to Alliance ENT & Hearing Center for any services furnished to me by Alliance ENT & Hearing Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_