Patient Name: _____ DOB_____
Last First MI
Gender: M F Social Security _____ Race: African American Asian Caucasian/White

Ethnicity: Hispanic Non-Hispanic Primary Language:_____ Marital Status:_____

Address: _____
Street City State Zip

Phone: _____
Home Work Cell

Preferred # _____Email: _____

Primary Care Physician: _____ Pharmacy/location: _____

Employer Name _____ Work Phone:_____

Spouse Name:_____ DOB_____ Phone# _____ Employer_____

Complete if patient is under 18 years of age or a student:

Parent/ Guardian Name & Relation _____ Phone: _____

EMERGENCY CONTACT (a person not living within the patient's home)

Name: _____ Relationship: _____

Address: _____ Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ ID #_____Group#_____

Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance:_____ID#_____Group#_____

Subscriber's Name: _____ Subscriber's DOB: _____

AUTHORIZATION

I do hereby request and authorize my insurance company &/or companies to pay directly to *Central Arkansas Ear, Nose and Throat Clinic* any proceeds payable under the terms of my policy &/or policies. I understand and agree any unpaid balance not covered by my policy &/or policies is my obligation and will be paid by me. I do hereby authorize this health care provider or its agent(s) to discuss the patient's account with the patient's insurance provider(s) or any other party in order to affect payment of any unpaid balance(s). Further, it is agreed that should the health care provider determine that it is necessary to employ an attorney &/or collection agent to recover any unpaid balance owed, I will pay any and all cost expended to affect collections, including attorney's fees &/or collection agent fees. If you fail to notify our office of your intent to cancel you will be charged $25.

_____

Signature (or Guardian's Signature) Date