Patient Information

Please Print

Date __________ Doctor You're Seeing Today ___________________________ SS# _____________

Patient Name____ Age _____________

Last First Middle

Address ____ Apt. # ____________

City ____ State__________ Zip________________

Phone # (___)__________________ Cell Phone # ________________ Pager # ____________________

Date of Birth _____ / _____ / _____ Marital Status *(circle one)* M S D W Sex M F

Employer____ Phone # (____)______________

Address ____

****

Spouse / Responsible Party Full Name ____

Address ____ Phone #______________

City _____________________________________ State ____ Zip _______ Date of Birth ___ / ___ / ___

S.S. #____________________________ Relation to Patient ___________________________________

Employer____ Phone # __________________

Address ____

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Person to contact in case of emergency *(not living with you)*___________________________________

Address ____________________________________ City_____________________ State ___________

Phone (day) ___________________ Relationship ____

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Primary Insurance ____

Policy Holder's Name & Address ____

Place of Employment ____

Subscriber ID # ____________________________________ Group No. ________________________

Relationship to Patient _____________________________________ Effective Date ______________

Insured's Date of Birth ____ / ____ / ____ Is referral needed? ________________________________

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Secondary Insurance ____

Policy Holder's Name & Address ____

Place of Employment ____

Subscriber ID # ___________________________________ Group No. _________________________

Relationship to Patient _____________________________________ Effective Date _____________

Insured's Date of Birth ____ / ____ / ____ Is referral needed? ________________________________

Did your physician ask you to see an ENT doctor? ____ yes ____ no

If yes, Name of your Physician ______________________ Primary Care Doctor __________________

Signature____ Date ___ / ___ / ___

________________________________ Office Use Only _________________________________

| Signature____ Date ___ / ___ / ___ |

| Signature____ Date ___ / ___ / ___ |

|____|

PLEASE Continue with Page 2 *(Authorization Forms)*

INSURANCE AND BILLING AUTHORIZATION

I understand that I am financially responsible to Kentuckiana Ear, Nose & Throat for any charges incurred for services performed regardless of insurance coverage.

I understand that Kentuckiana Ear, Nose & Throat will file a claim for my services but that I am responsible for any and all amounts not covered and not paid by my insurance carrier. **If my insurance requires a referral for my office visit, I understand that it is my responsibility to obtain this and present it at the time of my visit (if not before).**

I hereby authorize Kentuckiana Ear, Nose & Throat to submit a claim to my Insurance Carrier or it's intermediaries for all covered services rendered by Kentuckiana Ear, Nose & Throat and direct my insurance carrier or it's intermediaries to issue payment check directly to Kentuckiana Ear, Nose & Throat.

Signature ____ Date __________

CONSENT FOR CARE AND TREATMENT OF DEPENDENT

I certify that I am the parent or legal guardian of _______________________________________
Dependent's Name

Of ____
Address

I give my consent to the physicians of Kentuckiana Ear, Nose & Throat to examine and render treatment as appropriate for the above named patient.

I understand that I am responsible for any balances owed (ie. co-pays, deductible, co-insurance, etc.).

I also understand that it is my responsibility to furnish this office with current insurance information should there be any change in my insurance coverage or I will be responsible for any charges incurred.

Signature of parent or guardian ____ Date_______

Relationship to Patient ____

MEDICARE AUTHORIZATION

I authorize the physicians of Kentuckiana Ear, Nose & Throat to submit all information necessary to the Federal Medicare Carrier and my Medigap carrier in order to file a claim for services provided to me.

I understand that Medicare will only pay for services that it deems medically necessary. I understand that there are also a number of services that Medicare considers noncovered and / or not medically necessary and that Medicare will not make payment for these services. These include hearing loss, hearing aids, cosmetic surgery and other services and supplies. I understand that my physician has reason to believe that Medicare may not cover part or all of the services rendered. I agree to be financially responsible for and pay for all services for which Medicare does not pay.

Signature of Patient ____ Date___________