ENT Specialties, PC

Personal Information

Today's Date: ____________ Account #: ____________ SSN: ____________

First Name: ____________ MI: ________ Last Name: ____________

Address: ____

Zip Code: ________ City: ____________ State: ____________

Date of Birth: ____________ Age: ________ Marital Status: ____________

Sex: ________ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Primary Phone: (***number you wish to be reachedat***) ____________ Other #: ____________

Email: ____________ Work No: ____________

Employer: ____________ Full Time Student: ☐ Yes ☐ No

In the event of an emergency or if patient is a minor please contact:

Name: ____________ Relationship: ________ Phone No: ____________

Primary Care Provider: ____________

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other ________

Referring Physician's Name: ____________ Phone No: ____________

Address: ____

Preferred Language:____Race:____

Ethnicity (Circle One): Hispanic or Non-Hispanic

<u>Text/Call Reminder Service:</u>

To provide better service for our patients, we have recently added a courtesy appointment (text/call) reminder. A call will be made 2-days prior to your scheduled appointment, and a text message will be sent to eligible mobile numbers 1-day prior. If you would like to opt out of this service, please mark the box below:

☐ I, ____, would like to opt out of the text/call reminder service.

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: ____________ Insured's Name: ____________

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: ____________ Group#: ____________ Insured's DOB: ____________

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: ____________________ **Date:** ____________