



PATIENT NAME: \_\_\_\_\_

Patient's Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Sex: Male / Female (circle one) Marital Status: Married / Single / Widowed / Divorced (circle one)

Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

INDICATE PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Spouse's Employer Phone: \_\_\_\_\_ Spouse's Cell Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ HM WK CELL

How is the patient related to this contact person? \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Ins. Co. \_\_\_\_\_

Secondary Ins. Co. \_\_\_\_\_

Name of Cardholder \_\_\_\_\_

Name of Cardholder \_\_\_\_\_

ID / Policy #: \_\_\_\_\_

ID / Policy #: \_\_\_\_\_

Cardholder's DOB: \_\_\_\_\_

Cardholder's DOB: \_\_\_\_\_

Co-pay: \_\_\_\_\_

Co-pay: \_\_\_\_\_

**Third Ins. Co.:** \_\_\_\_\_  
Name of Cardholder: \_\_\_\_\_  
ID / Policy #: \_\_\_\_\_  
Cardholder DOB: \_\_\_\_\_

**COMPLETE THIS SECTION IF THE PATIENT IS A MINOR OR FULL TIME STUDENT**

Father/Guardian: \_\_\_\_\_ SSN# \_\_\_\_\_ Birth Date: \_\_\_\_\_

\*\* Address if not the same as patient's listed above\*\*

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Hm #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ SSN# \_\_\_\_\_ Birth Date: \_\_\_\_\_

\*\* Address if not the same as patient's listed above\*\*

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Hm #: \_\_\_\_\_ Cell# \_\_\_\_\_

Step-parent Name: \_\_\_\_\_ SSN# \_\_\_\_\_ Birth Date: \_\_\_\_\_

\*\* Address if not the same as patient's listed above

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Hm #: \_\_\_\_\_ Cell# \_\_\_\_\_

I authorize ENT Clinic of Iowa, P.C. to furnish information to insurance carriers concerning my illness and treatments and hereby assign the clinic all payments for services rendered to dependents or myself. **I understand that I am responsible for amounts not covered by my insurance.**

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