

# Midwest ENT Centre Patient Information

JMC KEB MLW MC RRM ACCT #

**Patient's Name** (Last, First, MI): \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_ **Zip** \_\_\_\_\_

Is it ok to send mail to this address?      **Y**      **N**

Home # \_\_\_\_\_ **Y** **N**    Work # \_\_\_\_\_ **Y** **N**    Cell # \_\_\_\_\_ **Y** **N**

**Is it ok to leave messages at these numbers? Please circle yes or no next to approved numbers**

E-mail Address \_\_\_\_\_

**Social Security Number** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Race** \_\_\_\_\_ **Ethnicity** \_\_\_\_\_ **Language Spoken** \_\_\_\_\_

**Marital Status**    Single / Married / Widowed / Separated / Divorced      **If Patient is a Minor are the biological**

**Parents:    Married / Divorced**

**Sex**    Male / Female      **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **Age** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Home #** \_\_\_\_\_ **Cell #** \_\_\_\_\_

**Primary Doctor** \_\_\_\_\_ **Referring Doctor** \_\_\_\_\_

**Responsible party** \_\_\_\_\_ (Relationship to Patient) \_\_\_\_\_  
(if other than self)

Patients Employer \_\_\_\_\_ **Phone #/Address** \_\_\_\_\_

## INSURANCE INFORMATION

**Medical Insurance**    Primary Subscriber \_\_\_\_\_ **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Social Security #** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Secondary Insurance**    Secondary Subscriber \_\_\_\_\_ **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Social Security #** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

## AUTHORIZATION OF RELEASE OF INFORMATION / CONSENT TO TREATMENT

- \* I hereby authorize Midwest ENT Centre, PC to release information necessary for my insurance company and/or Medicare to process my claim, and to receive authorized direct payment of insurance benefits otherwise payable to me under the terms of my insurance.
- \* I am responsible for my co-payment at the time services are rendered as well as any balance due after insurance has processed my claim(s). If uninsured, I am responsible for all charges incurred throughout my care at Midwest ENT Centre, PC.
- \* I am responsible for obtaining referrals as required by my insurance for services rendered by Midwest ENT Centre, PC.
- \* I understand that if collection should ever be required on my account, collection expenses will be incurred by the responsible party on my account. \* I have completed this form and attest to the accuracy of all the information I have provided.

(COPY OF NOTICE OF PRIVACY PRACTICES AVAILABLE AT FRONT DESK RECEPTION)

**Midwest ENT is authorized to release my information to the following individual (List names and relationships)**

\_\_\_\_\_  
Parent/ spouse/ children, etc.

**X** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Patient/Guardian