EMERGENCY CONTACT:

NAME:_____

PHONE:_____

L·E·N·T·S
Louisiana Ear Nose Throat & Sinus

I. PATIENT INFORMATION

Patient _____ Title: Mr./Mrs./Other _____ Suffix: Jr./Sr ./Other _____
Last First Middle

Sex: Male / Female Race _____ Ethnicity _____

DOB_____ Social Security #_____ Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Mailing Address _____
City State Zip

Hm. Ph. _____ Wk Ph. _____ Ext. _____ Cell Ph. _____ Primary Ph._____

Employer _____ Student: ❑ Full ❑ Part-time

Employment Status: ❑ Full-time ❑ Self Employed ❑ Part-time ❑ Not Employed ❑ Unknown ❑ Retired ❑ Military Active

Referred by_____ Email: _____

PHI: I authorize you to release Protected Health Information to the following person(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

II. RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Name _____ Title: Mr./Mrs./Other _____ Suffix: Jr./Sr./Other _____
Last First Middle

Sex: Male / Female Race _____ Ethnicity _____

DOB_____ Social Security #_____ Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Mailing Address _____
City State Zip

Hm. Ph. _____ Wk Ph. _____ Ext. _____ Cell Ph. _____ Primary Ph._____

Employer _____ Work Status: _____ Email: _____

III. INSURANCE INFORMATION

PRIMARY	SECONDARY/SUPPLEMENTAL
Insurance Company _____	Insurance Company _____
Patient's Relationship to Policy Holder: ❑Self ❑Child ❑Mate ❑Other	Patient's Relationship to Policy Holder: ❑Self ❑Child ❑Mate ❑Other
Group # _____ Policy/ID # _____	Group # _____ Policy # _____
POLICY HOLDER'S NAME_____	**POLICY HOLDER'S NAME**_____
Address _____	Address _____
_____	_____
City State Zip	City State Zip
Social Security # _____	Social Security # _____
Hm. Ph._____ Wk Ph._____Ext._____	Hm. Ph._____ Wk Ph._____Ext._____
DATE OF BIRTH_____Sex: M or F	**DATE OF BIRTH**_____Sex: M or F
Race_____ Ethnicity _____ Marital Status _____	Race_____ Ethnicity _____ Marital Status _____
EMPLOYER _____ Work Status _____	**EMPLOYER** _____ Work Status _____

I hereby authorize ENT Medical Center to furnish information to insurance carriers (and doctor's offices) concerning my illness and treatments. This signature also authorizes you to give me reasonable and proper care by today's standards. I understand that I am responsible for all fees, regardless of my insurance coverage. In order to expedite insurance company payments, the necessary forms will be completed by this office. It is customary to pay for services when rendered unless other arrangements have been made in advance. I will also be responsible for any legal or other costs incurred in the collection of this account.

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices.

Signature Date

I plan to pay for today's visit by:
❑ Cash ❑ Check ❑ Credit Card