Arkansas Ear, Nose & Throat

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 reached at) _____ Other #: _____

Occupation: _____ Work No: _____

Employer: _____ Personal Email: _____

In the event of an emergency please contact:

Name:_____ Relationship:_____ Phone No:_____

For Minor Patients: Name of Parent/Guardian:_____

Parent/Guadian SSN:_____ DOB:_____

Referring Physician's Name:_____ Phone No:_____

Insurance Information:

Primary Insurance: _____ Relation to insured _____

Policy holders name:_____ Policy holders DOB:_____

Secondary Insurance: _____ Relation to insured:_____

Policy holders name:_____ Policy holders DOB:_____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

By signing below, I understand I will be responsible for all billable services not covered by insurance.

I authorize Arkansas Ear, Nose, & Throat, PA to release medical information necessary to claim reimbursement from insurance companies. I assign the claim payment to be made to Arkansas ENT. This authorization may be revoked at any time by written notice.

RELEASE OF RECORDS

I authorize the release of personal health information to the following person(s)_____

MISSED APPOINTMENT CHARGES

Physicians have the authority to charge a patient $50.00 for any appointments that you do not show up for without prior notification to the office. Initials:_____

Patient/Guardian Signature: X_____ **Date:** _____