



Acct# _____

Staff Initials _____

Provider _____

Name: _____
First Middle Last

Date of Birth: ____/____/____ Sex: Male / Female Marital Status: Single / Married / Widow / Divorced

Social Security#: ____/____/____ Email address: _____

Address: _____
Street or PO Box City State ZIP

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Patient Employer: _____ Language: _____ Ethnic: _____ Race: _____

Patient's Spouse: _____ Spouse Employer: _____ Phone: (____) _____

Referring Doctor: _____ Family Doctor: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Primary Insurance: _____ Name of Policy Holder: _____

Date of Birth: ____/____/____ Relationship to Patient: _____ Employer: _____

Insurance ID#: _____ Group#: _____ Copayment: _____

Secondary Insurance: _____ Name of Policy Holder: _____

Date of Birth: ____/____/____ Relationship to Patient: _____ Employer: _____

Insurance ID#: _____ Group#: _____ Copayment: _____

***** Please complete the following if the patient is a minor or full time student *****

Parent Name: _____ Date of Birth: ____/____/____ Phone: (____) _____

Address if different than patients: _____

Employer: _____ Employer Phone: (____) _____

Parent Name: _____ Date of Birth: ____/____/____ Phone: (____) _____

Address if different than patients: _____

Employer: _____ Employer Phone: (____) _____

How did you hear about our clinic? (Mark one box) Doctor Insurance Plan Family/Friend Yellow Pages/Internet

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Iowa ENT Center or its billing company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____