

New Patient Information

Patient's Name: First _____ MI _____ Last _____

Date of Birth _____ Age _____ Male/Female _____ Soc. Sec. # _____

Address _____ Marital Status: M S D W SEP

City _____ State _____ Zip _____ Home Phone _____

Patient's Employer _____ Work Phone _____

Spouse's Name _____ Date of Birth _____ SSN _____

Spouse's Employer _____ Work Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Insurance Information

Medicare Number _____ Arkansas Medicaid Number _____

Please list insurance information below and present a copy of your insurance card if you would like for us to file your insurance.

Insurance Company _____

Policyholder's Name _____ Date of Birth _____ Relationship to Patient _____

Insurance Company _____

Policyholder's Name _____ Date of Birth _____ Relationship to Patient _____

Medical Information

Family Physician's Name _____ Referred By _____

Pharmacy Name and City _____

Authorization to Release Information

I authorize the release of the medical information necessary to process my insurance claims, to physicians I may be referred to in the future and the physician who referred me to this practice.

Signature _____ Date _____

Authorization of Payment

I authorize payment of medical benefits to Ear, Nose and Throat Associates of Mountain Home, P.A. for medical services provided. I understand that I am responsible for all fees regardless of my insurance coverage excluding those fees which are processed on assignment through contractual agreement.

Signature _____ Date _____