St Joseph’s Ear, Nose & Throat Clinic • 323 N Spokane St Suite 100 • Post Falls, ID 83854 • (208) 777-1320

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient’s Last Name | First | | Middle | | Date of Birth |
| Marital Status:  ⃝ Married ⃝ Single ⃝ Divorced ⃝ Widow | | | Gender:  ⃝ Female ⃝ Male | | SSN#: |
| Mailing Address: | | | City / State / Zip: | | |
| Home Phone: | | Cell Phone: | | Email: | |
| Race:  ⃝ White ⃝ Black ⃝ Hispanic  ⃝ Other \_\_\_\_\_\_\_\_\_\_ ⃝ Declined | | Ethnicity:  ⃝ Hispanic / Latino ⃝ Declined  ⃝ Not Hispanic / Latino | | Preferred Language:  ⃝ English  ⃝ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Primary Care Physician: | | | Referring Physician: | | |

|  |  |  |
| --- | --- | --- |
| Emergency Contact Name: | Phone Number: | Relationship to Patient: |

Guarantor (if patient is under 18):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name: | First: | | Date of Birth: | SSN#: |
| Mailing Address: | | City / State / Zip: | | |
| Home Phone: | Cell Phone: | | Email: | |
| Relationship to Patient: | |  | | |

Please **Initial** the Following:  
\_\_\_\_ I give my permission to discuss my health information with the following individual(s): **PLEASE SPECIFY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_ I give my permission to leave messages on my answering machine regarding appointments, routine test results and prescriptions.  
\_\_\_\_ I give my permission to call me at work. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all of this information is true and complete. I understand that I am responsible to pay for all services rendered to me and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. (PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE PHYSICIAN AND IS NOT A SUBSTITUTE FOR PAYMENT.)  
If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney’s fees and costs of collections. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to me or my dependent. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature (RESPONSIBLE PARTY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

MEDICARE ASSIGNMENT/SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made directly to St. Joseph’s Ear, Nose & Throat Clinic, for any service provided to me by Thomas R. deTar, M.D., F.A.C.S, and/or M. Erik Gilbert, M.D. and/or Michelle Cano-Keighley, NP. I authorize St. Joseph’s Ear, Nose & Throat Clinic, to release information to HCFA and its agents any information needed to determine benefits.

Signature (RESPONSIBLE PARTY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_