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: _____