



Patient's Last Name	First	Middle	Date of Birth
Marital Status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widow		Gender: <input type="radio"/> Female <input type="radio"/> Male	SSN#:
Mailing Address:		City / State / Zip:	
Home Phone:	Cell Phone:	Email:	
Race: <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> Hispanic <input type="radio"/> Other _____ <input type="radio"/> Declined	Ethnicity: <input type="radio"/> Hispanic / Latino <input type="radio"/> Declined <input type="radio"/> Not Hispanic / Latino	Preferred Language: <input type="radio"/> English <input type="radio"/> Other _____	
Primary Care Physician:		Referring Physician:	
Emergency Contact Name:	Phone Number:	Relationship to Patient:	

**Primary Insurance:**

Name Of Insurance:	Date of Birth:	Policy #:	Group #:
Name of Insured:	Relationship to patient:		
Address Of Insurance Company:	City / State / Zip:	Phone Number:	

**Secondary Insurance (If Applicable):**

Name Of Insurance:	Date of Birth:	Policy #:	Group #:
Name of Insured:	Relationship to patient:		
Address Of Insurance Company:	City / State / Zip:	Phone Number:	

**Guarantor (if patient is under 18):**

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

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 Chad McCormick, M.D., F.A.A.O.A., and/or Philip Gardner, M.D/ or Anne Sobba-Higley, MD . 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: \_\_\_\_\_