MT SCOTT EAR, NOSE AND THROAT, & SLEEP MEDICINE

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Patient Information

First Name:	Middle:	Last Name:	
Address:		Age:	DOB:
Home Phone:	Marital Status:	SS#:	Sex: M/F
Cell Phone:	Work Phone:	Email:	
Primary Care Physician:		PCP Phone Number:	

Patient's Employer

Employer:		Business Phone:	
Address	City:	State:	Zip:
Occupation:		Length of Employment:	

Insurance Information

Insurance Company Name:		Insured's SS#:	
Address:	City:	State:	Zip:
Group Number:	ID Number	Name of Insured	
Insurance Phone Number:		Insured's Date of Birth:	

Secondary Insurance

Insurance Company:	Insurance Phone Number:	Insured's SS#:	
Address:	City:	State:	Zip:
Group Number:	ID Number:	Name of Insured:	Insured's DOB:

Responsible Party (If Not Patient)

First Name:	Middle:	Last Name:	
Address:	City:	State:	Zip:
Employer:	Employer Phone #:	Relationship to Patient:	DOB:

Emergency Contacts

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

I hereby authorize MT Scott ENT and Sleep Medicine to furnish the insured's insurance company all the information which said insurance company may request concerning my present illness of injury. I hereby assign to the said doctor all the money to which I am entitled for medical and/or surgical expense received from the above named insurance company(s) over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by insurance payments. I understand there is a $25 charge for returned checks and a service charge on accounts over 90 days past due.

Patient or Gaurdian's Signature:	**Date**