

9200 SE 91st Ave, Suite 200
 Portland, OR 97086
 P: 503.233.5548 F: 503.230.1009
www.MtScottENT.com

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

Patient's Employer			
Employer:	Business Phone:		
Address	City:	State:	Zip:

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:
---	--------------

