MT SCOTT EAR, NOSE AND THROAT, & SLEEP MEDICINE

9280 SE Sunnybrook Blvd. Ste 300
Clackamas, OR 97015
P: 503.233.5548 F: 503.230.1009
www.MtScottENT.com

Patient Information

First Name: Middle: Last Name:

Address: Zip: DOB:

Home Phone: Cell Phone: SS#: Sex: M/F

Email Address: Marital Status:

Primary Care Physician: PCP Phone Number:

Employer: Work Phone:

Insurance Information

Insurance Company Name: Insurance Phone Number:

Member ID/Policy Number: Group Number:

Policy Holder Name/Relation: Policy Holder DOB:

Secondary Insurance

Insurance Company Name: Insurance Phone Number:

Member ID/Policy Number: Group Number:

Policy Holder Name/Relation: Policy Holder DOB:

Responsible Party (If Not Patient)

First Name: *Middle:* Last Name:

Address: *City:* State: Zip:

Relationship to Patient: DOB:

Emergency Contacts

Name: *Relationship:* Phone Number:

Name: *Relationship:* Phone Number:

Permission to Leave a Detailed Message

_____ I authorize the medical providers and staff of Mt. Scott ENT to leave a detailed message at the following phone number/s:

1.) _____ 2.) _____

_____ I decline. Please do not leave me a detailed message.

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 Guardian's Signature: Date: