

Dubuque ENT Head & Neck Surgery PC

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The information you provide to this office helps us to help you with important items such as: future appointments, insurance claim processing, payment on your account, etc. It could also be critical in the event of an emergency.

Patient Information:

Name: _____

First Middle Last

Address: _____

City State Zip

Social Security #: _____ Sex (M) (F)

How did you hear about this office?: Doctor _____
Friend _____ Relative _____ Ad _____ Yellow Pages

Is this Work Comp?: _____

Email Address: _____

Date: _____/_____/201____

Age: _____

Birthdate: _____/_____/_____

Phone Home: (_____) _____

Work: (_____) _____

Cell: (_____) _____

Employer: _____

Marital Status: _____S _____M _____D _____W

Your insurance card **MUST** be presented at the time of service. Co pays and Deductibles are due at the time of service.

Primary Insurance:

Insurance Co.: _____

Policy Holder: _____

Policy ID #: _____

Birthdate: _____/_____/_____SS# _____

Employer: _____

Secondary Insurance:

Insurance Co.: _____

Policy Holder: _____

Policy ID #: _____

Birthdate: _____/_____/_____SS# _____

Employer: _____

If Patient Is A Minor Please List Parent Information

Father (Full Name): _____

Birthdate: _____/_____/_____SS# _____

Address: _____

Phone: (H) _____ (W) _____

(Cell) _____

Employer: _____

Marital Status: _____M _____S _____D _____W

Mother (Full Name): _____

Birthdate: _____/_____/_____SS# _____

Address: _____

Phone: (H) _____ (W) _____

(Cell) _____

Employer: _____

Marital Status: _____M _____S _____D _____W

Name of The Person Responsible For This Account: _____

Emergency Contact: (Outside your household) Name: _____

Address: _____

Phone: (H) _____ (W) _____ (Cell) _____

Statement of File Signature & Assignment of Benefits

1. I authorize release of information to my insurance companies, employer, work comp carrier, Medicare or Medigap.
2. I understand that I am fully responsible for my bill.
3. I authorize my insurance companies, Medicare & Medigap, work comp carrier &/or employer to issue payment directly to my physician.
4. I authorize use of this form on all of my claims submissions.
5. I authorize Dubuque ENT to intercede on my behalf in helping me secure payment of any and all claims.

Date _____/_____/201____

Signature _____