

PATIENT INFORMATION

Name: _____ Sex: _____ Marital Status: _____
Last First M.I.

Address: _____
Number Street City State Zip

Date of Birth: ___/___/___ SSN#: ___/___/___ Email _____

Preferred Method of Contact: Follow My Health Portal Phone Mail

Please circle Yes or No if a detailed message can be left at these contact numbers-

Home No : (____) _____ Y N Cell No: (____) _____ Y N Work No: (____) _____ Y N

Primary Doctor: _____ Referring Doctor: _____
First and Last Name First and Last Name

Employer: _____ Occupation: _____ Retired: ___ Student: ___

Person to notify in case of emergency: _____ Phone: ___/___/___

Primary Insurance Subscriber Information

Name: _____ DOB: ___/___/___ Relationship to Patient _____

Home Address: _____ SSN: ___/___/___

Home No : (____) _____ Cell # : (____) _____

Secondary Insurance Subscriber Information

Name: _____ DOB: ___/___/___ Relationship to Patient _____

Home Address: _____ SSN: ___/___/___

Home No : (____) _____ Cell # : (____) _____ I have a 3rd insurance

AUTHORIZATION OF RELEASE OF INFORMATION / CONSENT TO TREATMENT / FINANCIAL RESPONSIBILITY

* I hereby authorize, Midwest ENT Centre, PC, to release information necessary for my insurance company and/or Medicare to process my claim, and to receive authorized direct payment of insurance benefits otherwise payable to me under the terms of my insurance.

* **I am responsible for my insurance co-payment at the time services are rendered as well as any balance due after insurance has processed my claim(s).** If uninsured, I am responsible for all charges incurred at the time of my visit throughout my care.

* **I am responsible for obtaining referrals as required by my insurance** for services rendered by Midwest ENT Centre, PC.

* I understand that if my account is sent to collections, there is an additional 25% fee that will be incurred.

* I have completed this form and attest to the accuracy of all the information I have provided.

Release of information: I authorize the *Release of My Information* (medical/financial) about my Midwest ENT visits to the following individuals:

Parent _____ Spouse _____ Children /Other _____
Name Name Name

Authorization to obtain medical records from your physician(s): I hereby authorize the following physicians

Physician(s) names that you previously have seen

To release my medical records including the diagnosis and records of any treatment or examination, including Test results, Audiograms/ENG, Sleep Study, CT Scan/MRI/Thyroid Ultrasound/FNA, Allergy Test Results, Pathology Reports, Operative Reports, lab results and reports rendered to me at any time to:

Midwest ENT Centre
4790 Executive Centre Blvd
St Peters, MO 63376
Phone: 636-441-3100
Fax: 636-441-8072

X _____ Date of Birth: ____/____/____
Signature of Patient/ or Guardian Relationship to Patient

Date: ____/____/____

(Please Print) *Patient **and** Guardian's Name*

X _____
Signature of the Guarantor (This is the person who is responsible for paying any balances.)

Thank you for choosing Midwest ENT Centre for your ear, nose and throat specialist.