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

Preferred Pharmacy_____

Your insurance card <u>MUST</u> 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:_____Relationship_____
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_____