

Foothills E.N.T.

Date: _____

FENT# _____

PLEASE PRINT

Patients Name: _____ Male _____ Female: _____
(Last) (First) (Middle) (Preferred name)

Mailing Address: _____ City: _____
(Street name and Number)

State: _____ Zip Code : _____ Home Phone: _____ Email address: _____

Street address (if different from above): _____

Age: _____ Date of Birth: _____ SS#: _____ Marital Status: M S D W

Employment: _____ Work Phone: _____ Cell Phone: _____

Name of spouse: _____ SS#: _____ Birthdate: _____

Spouse's Employment _____ Phone: _____ Ext: _____

IF PATIENT IS A CHILD/STUDENT:

Mother's Name: _____ SS#: _____ Birthdate: _____

Mothers Employment: _____ Bus. Phone: _____ Cell Phone: _____

Father's Name: _____ SS#: _____ Birthdate: _____

Fathers Employment: _____ Bus. Phone: _____ Cell phone: _____

School Currently Attending: _____ City & State: _____

OTHER INFORMATION:

Family Physician: _____ Phone #: _____ City & State: _____

Who referred you to our office? _____

Reason you are being seen to day? _____

Emergency contact (someone outside of your current residence): Name: _____

Relationship: _____ Phone Number: _____

Pharmacy you currently use: _____ City: _____ Phone #: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Insured: _____ ID/Group #: _____

Secondary Insurance: _____ Insured: _____ ID/Group#: _____

I authorize Foothills E.N.T. to furnish my insurance company medical and any other information necessary to process insurance claims. I hereby assign payment of insurance benefits on services rendered. I understand that I am responsible for any health insurance co-payments, co-insurance, deductibles, non-covered services, or remaining charges. This authorization also gives my consent for treatment.

I am aware that if my account goes over 60 days with no payment, a collection process may begin. In the event an outside collection agency becomes necessary, my account may be charged a collection fee.

Signature: _____ Date: _____
(Patient/Parent/Legal Representative)