ROCKY MOUNTAIN EAR NOSE AND THROAT
PATIENT INFORMATION

Date:_____

Patient's Name: (last) _____(first) _____(mid initial) _____
Mailing address: _____
City:_____ Zip:_____
Phone numbers: Home:_____Mobile:_____
Email:_____
Date of Birth (mm/dd/yyyy):____/____/_____ Age:_____ Sex: M/F SSN:_____
Marital Status: ☐Married ☐Single ☐Divorced ☐Other:
Patient Employer: _____Work Phone: _____
Emergency Contact: _____Phone: _____

GUARANTOR INFORMATION

Person responsible for payment: _____

Relationship to patient: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Insured's Name: _____ Member ID: _____

Group Number: _____

Secondary Insurance (if any): _____

Primary Care Physician (PCP): _____ Referring Physician: _____

Have you previously been seen at our practice? Y/ N Date Last Seen: _____

VOICE MESSAGE CONSENT

If I am unable to be reached directly by phone, I authorize you to leave voice messages for me at the following number(s): Home: _____Work: _____Cell: _____Other: _____
I give permission for: _____to receive my information.
Phone Number: _____

AUTHORIZATIONS AND PRIVACY PRACTICES

Payment and Release of Information: By signing below, [hereby authorize payment to be made directly to my physician, for medical and/or surgical benefits, if any. A copy of this authorization shall be valid as the original. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance. I hereby authorize ROCKY MOUNTAIN ENT GROUP to release information requested by my insurance company, I also authorize ROCKY MOUNTAIN ENT GROUP to release information to any hospital or physician I may be referred to by this office.
Notice of Privacy Practices: By signing below, I hereby acknowledge that I received a copy of the Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____