

Welcome to our practice. Please fill out the information found below to the best of your ability.

Patient's Name	Date of Birth	Age
Street	Home Phone #	
City	ST	ZIP
Soc. Sec. No.		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
Personal Email Address:		

SPOUSE INFORMATION		
Spouse's Name	Date of Birth	Soc. Sec. No.

EMPLOYMENT INFORMATION		
Patient's Employer	Work Phone #	ext.
Employer's Address	Cell Phone #	
Spouse's Employer:	Work Phone #	ext.
Address:	Cell Phone #	

Emergency Phone Number _____ May we contact you at work? _____

PHARMACY INFORMATION	
Name _____	Phone _____
Allergies _____	

INSURANCE INFORMATION	
PRIMARY INSURANCE	
DO YOU HAVE <input type="checkbox"/> Group coverage through your employer <input type="checkbox"/> Group through your Spouse's Employer	
<input type="checkbox"/> Medicare <input type="checkbox"/> Individual policy	
<input type="checkbox"/> Other (Please List) _____	
Please provide your policy information in the space below:	
Insured	
Insurance Company	
Address	
Insurance Supplement or Policy Number	

PROCEDURE ADVISEMENT - Due to the nature of some of your or your dependent's presenting symptoms it is possible that the doctor will need to perform a diagnostic or therapeutic procedure in order to accurately and successfully diagnose and/or treat your or your dependent's condition. These services are billed separately and may be classified as surgery by some insurance carriers. Additionally, many primary sinus surgery procedures have planned and staged therapeutic post operative surgical procedures which are also separately billable, and are not included in the global fee for the primary surgery.

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS	
I authorize Iowa ENT & Sinus Surgery Center, P.C. to release to the Medicare carrier and/or the Insurance Carrier listed above, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of this claim be made directly to Iowa ENT & Sinus Surgery Center, P.C.	
I understand that I am financially responsible for all charges incurred.	
Date _____	Signature _____

Who may we thank for referring you: _____