

Account # _____

ENT Medical Center
5258 Dijon Drive
Baton Rouge, LA 70808
(225) 769-1090

F/C _____

Resp. Party # _____

DR _____ LOC _____

I. PATIENT INFORMATION

Patient _____ Title: Mr./Mrs./Other _____ Suffix: Jr./Sr./Other _____
Last First Middle

Mailing Address _____
City State Zip

Hm. Ph. _____ Wk Ph. _____ Ext. _____ Cell Phone _____ Sex: M or F

DOB _____ Social Security # _____ Marital Status: Married Single Widowed Divorced

Employer _____ Student: Full Part-time

Employment Status: Full-time Self Employed Part-time Not Employed Unknown Retired Military Active

Referred by _____ Date of Injury _____ Is the injury work related? _____

II. RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Name _____ Title: Mr./Mrs./Other _____ Suffix: Jr./Sr./Other _____
Last First Middle

Mailing Address _____
City State Zip

Hm. Ph. _____ Wk Ph. _____ Ext. _____ Cell Phone _____ Sex: M or F

DOB _____ Social Security # _____ Employer _____

Employment Status: Full-time Self Employed Part-time Not Employed Unknown Retired Military Active

III. INSURANCE INFORMATION

Do you have Medicare? Yes No

Do you have Medicaid? Yes No

PRIMARY

SECONDARY/SUPPLEMENTAL

Insurance Company _____

Insurance Company _____

Patient's Relationship to Policy Holder: Self Child Mate Other

Patient's Relationship to Policy Holder: Self Child Mate Other

Group # _____ Policy # _____

Group # _____ Policy # _____

CoPay: Primary Care _____ Specialist _____

CoPay: Primary Care _____ Specialist _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S NAME _____

Address _____

Address _____

City State Zip

City State Zip

Social Security # _____

Social Security # _____

Hm. Ph. _____ Wk Ph. _____ Ext. _____

Hm. Ph. _____ Wk Ph. _____ Ext. _____

DATE OF BIRTH _____ Sex: M or F

DATE OF BIRTH _____ Sex: M or F

EMPLOYER _____ Status _____

EMPLOYER _____ Status _____

I hereby authorize ENT Medical Center to furnish information to insurance carriers (and doctor's offices) concerning my illness and treatments. This signature also authorizes you to give me reasonable and proper care by today's standards. I understand that I am responsible for all fees, regardless of my insurance coverage. In order to expedite insurance company payments, the necessary forms will be completed by this office. It is customary to pay for services when rendered unless other arrangements have been made in advance. I will also be responsible for any legal or other costs incurred in the collection of this account.

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices.

Signature

Date

I plan to pay for today's visit by:

Cash Check Credit Card