

EASTERN OKLAHOMA EAR, NOSE, AND THROAT, INC.

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____ MI _____ SS# _____

ADDRESS _____ CITY/STATE/ZIP _____

BIRTHDATE _____ SEX _____ MARITAL STATUS _____

PHONE- HOME() _____ WORK () _____ EXT. _____ CELL () _____

Primary Care Physician: Last Name _____ First Name _____

Referring Physician: Last Name _____ First Name _____

Pharmacy name _____ Location _____ Phone number _____

CLOSEST RELATIVE NOT LIVING WITH YOU

NAME: _____ PHONE :() _____ - _____

INSURANCE INFORMATION – PLEASE COMPLETE

RESPONSIBLE PARTY:

PLEASE CIRCLE:

SELF FATHER SPOUSE GUARDIAN

SELF MOTHER SPOUSE GUARDIAN

NAME _____

NAME _____

RELATIONSHIP _____

RELATIONSHIP _____

BIRTHDATE _____

BIRTHDATE _____

SSN# _____ - _____ - _____

SSN# _____ - _____ - _____

ADDRESS _____

ADDRESS _____

CITY/STATE/ZIP _____

CITY/STATE/ZIP _____

CELL PHONE _____

CELL PHONE _____

EMPLOYER _____

EMPLOYER _____

HOME PHONE () _____

HOME PHONE () _____

WORK PHONE () _____

WORKPHONE () _____

PRIMARY INSURANCE:

SECONDARY INSURANCE:

INSURANCE COMPANY _____

INSURANCE COMPANY _____

CARD HOLDER _____

CARD HOLDER _____

CARD HOLDER DATE OF BIRTH _____

CARD HOLDER DATE OF BIRTH _____

EMPLOYER _____

EMPLOYER _____

I.D# _____ GROUP# _____

I.D# _____ GROUP# _____

FINANCIAL RESPONSIBILITY & AUTHORIZATION TO RELEASE INFORMATION

I hereby assign to Eastern Oklahoma Ear, Nose, & Throat Inc., any and all rights and interest in insurance benefits and direct that all such payments be made directly to the clinic. I understand that I am financially responsible for all deductibles, coinsurance and all services not covered by insurance benefits and/or entitlements.

Eastern Oklahoma Ear, Nose, & Throat, Inc. physicians have a financial interest in Tulsa Spine & Specialty Hospital, LLC, (TSSH), & Imaging Solutions. Your physician may refer you to the TSSH facility or Insight Diagnostics where medical procedures may be performed. The Oklahoma Financial Disclosure Statute requires that we inform you of your physician's financial interest in Tulsa Spine& Specialty and Imaging Solutions.

I acknowledge the disclosure, and authorize any holder of information about me to release to the health plan indicated, and information needed to determine these benefits payable to related services.

SIGNATURE _____ DATE _____