SOUTHWEST OHIO ENT SPECIALISTS, INC
(FORMERLY: DAYTON HEAD & NECK SURGEONS)

PATIENT INFORMATION

Name (Last) _____ (First) _____ Initial _____

SS# _____ Date of Birth _____ Age _____

Address _____

City / State / Zip _____

☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Male ☐ Female

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Phone _____ Name _____

Relationship to Patient _____

Employed: ☐ Yes ☐ No ☐ Retired ☐ Full-time Student ☐ Part-time Student

Employer: _____

Referring Doctor's Name (Last) _____ (First) _____ City _____ Phone _____

Family Doctor's Name (Last) _____ (First) _____ City _____ Phone _____

PERSON RESPONSIBLE FOR PAYMENT OTHER THAN PATIENT (Only one per family)

Name (Last) _____ (First) _____ Initial _____

Address _____ City / State / Zip _____

Home Phone _____ Work Phone _____ Birthdate _____

SS# _____ Employer _____

Relationship to Patient _____ If retired, from _____

MEDICAL INSURANCE INFORMATION (Please give clerk your insurance cards so we can make copies for our records.)

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers. Please show all numbers on your card(s). This will eliminate billing to you because of incomplete information.

PATIENTS WITH MEDICARE: Is your spouse actively working and have health insurance coverage: ☐ YES ☐ NO

PRIMARY INSURANCE CO. _____

Cardholder's Name _____ Patient's Relationship to Cardholder _____

I.D.# _____ Group # _____

Cardholder's Birthdate _____ SS# _____

SECONDARY INSURANCE CO. _____

Cardholder's Name _____ Patient's Relationship to Cardholder _____

I.D.# _____ Group # _____

Cardholder's Birthdate _____ SS# _____

I authorize **Southwest Ohio ENT Specialists, Inc.,** to provide diagnostic and treatment services to me. All rendered services, including any changes or updates in existing treatment, will be discussed with me prior to their implementation.

I authorize **Southwest Ohio ENT Specialists, Inc.,** to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier to issue payment check(s) directly to **Southwest Ohio ENT Specialists, Inc.**

I authorize **Southwest Ohio ENT Specialists, Inc.,** to furnish complete information to my insurance carriers or its intermediaries regarding services rendered.

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

My signature indicates my consent for treatment and that the information I have provided is correct.

Signature of Patient/Parent/Legal Guardian _____ Date _____

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