Ear, Nose & Throat specialty care

PATIENT INFORMATION

Michael B. Kronenberger, MD
Lance E. Oxford, MD
Dylan C. Lippert, MD
Lisa A. Redman, AuD
Audiology and Hearing Aids

Name: (Last) _____ (First) _____(Middle) _____

Address: _____(City) _____(State) _____(Zip) _____

PATIENT DATA

Home Phone: (_____) _____

Cell Phone: (_____) _____

Social Security #:_____

Birthdate: _____/_____/_____ Age:_____

Sex:_____ Occupation:_____

Employer: _____

Work Phone: (_____) _____

Email: _____

EMERGENCY DATA (Friend or Relative NOT living with you)

Name: _____

Phone: _____

FAMILY DATA

Spouse's Name:_____

Spouse's Employer: _____

Spouse's Phone: (_____) _____

If PATIENT is a MINOR, Complete Below

Father's Name: _____

Father's Employer: _____

Father's Phone: _____

Mother's Name: _____

Mother's Employer: _____

Mother's Phone: _____

Referred By: _____Physician? YES/NO

Primary Physician: (Last)_____,(First)_____

Family Members Previously Seen In This Office: _____

INSURANCE

POLICY HOLDER of PRIMARY Insurance: _____ Relationship to Patient: _____

Social Security # of Policy Holder: _____ Birthdate: _____/_____/_____ Age: _____

POLICY HOLDER of SECONDARY Insurance: _____ Relationship to Patient: _____

Social Security # of Policy Holder: _____ Birthdate: _____/_____/_____ Age: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Home Phone: (_____) _____

Relationship to Patient: _____ Birthdate: _____/_____/_____ Age: _____

Insurance Company: _____

I directly assign all medical/ surgical benefits to Ear, Nose & Throat Specialty Care, PLLC and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original. Medicare patients please note that you are signing a one-time authorization, and regulations pertaining to Medicare assignment of benefits apply. I understand that this authorization is valid for 1 year following the date listed below.

Signature: _____ Date: _____