

RIVER CITIES ENT SPECIALISTS

Joseph B. Touma, M.D. J. Brett Chafin, M.D. Scott R. Gibbs, M.D. B. Joseph Touma, M.D.

IMPORTANT NOTICE: Office policy and insurance regulations require that all co-payment, co-insurance and deductibles be paid at the time of your appointment.

Date: _____ Scheduled with: _____
 Consultation requested by: (PHYSICIAN'S FULL NAME:) _____
 City & State: _____ PHYSICIAN'S PHONE: _____

PLEASE PRINT

P A T I E N T	PATIENT'S FIRST NAME		MIDDLE NAME	LAST NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DRIVER'S LICENSE NO.	AGE	DATE OF BIRTH MO. DAY YR.	
	PATIENT'S STREET ADDRESS				APT. NO.	CITY	STATE	ZIP	
	PATIENT'S SOCIAL SECURITY NO.				RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/> STEPCHILD <input type="checkbox"/> CHILD		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED		
	RESIDENCE PHONE NUMBER ()		WORK PHONE NUMBER ()		MOBILE PHONE NUMBER ()		E-MAIL ADDRESS		
	PATIENT'S EMPLOYER & EMPLOYER'S ADDRESS						POSITION	HOW LONG	
S P O U S E	FULL NAME OF SPOUSE OR PARENT			SOCIAL SECURITY NUMBER		DATE OF BIRTH MO. DAY YR.			
	RESPONSIBLE PARTY'S STREET ADDRESS				APT. NO.	CITY	STATE	ZIP	
	EMPLOYER OF RESPONSIBLE PARTY & EMPLOYER'S ADDRESS				POSITION	HOW LONG	BUSINESS PHONE ()		
I M P O R T A N T	NEAREST RELATIVE NOT LIVING AT SAME ADDRESS			RELATIONSHIP TO PATIENT		PHONE NUMBER ()			
	STREET ADDRESS				APT. NO.	CITY	STATE	ZIP	
	ACCIDENT/INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO DATE _____ TIME _____ WHERE HAPPENED? <input type="checkbox"/> WORK <input type="checkbox"/> HOME <input type="checkbox"/> SCHOOL <input type="checkbox"/> AUTO						COMPLAINT/INJURY		
	IF WORKER'S COMPENSATION FILL IN CLAIM NO. _____								
	DRUG ALLERGIES: PLEASE LIST								
I N S U R A N C E	PATIENT'S PRIMARY INSURANCE COMPANY				PATIENT'S SECONDARY INSURANCE COMPANY				
	CITY		STATE	ZIP	CITY		STATE	ZIP	
	POLICY NO. (GROUP, CERT., SOC. SEC. NO.)				POLICY NO. (GROUP, CERT., SOC. SEC. NO.)				
	NAME OF POLICYHOLDER			DATE OF BIRTH		NAME OF POLICYHOLDER			DATE OF BIRTH
	RELATIONSHIP TO PATIENT			EMPLOYER		RELATIONSHIP TO PATIENT			EMPLOYER

All charges incurred will be the responsibility of the patient, or that of his or her parents, guardian, or agent.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment directly to River Cities ENT Specialists, PLLC.

Signed _____
 (Patient or Parent if Minor)

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize River Cities ENT Specialists, PLLC to release any information to my insurance company acquired in the course of my examination or treatment.

Signed _____
 (Patient or Parent if Minor)

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to River Cities, Ear, Nose & Throat Specialist, PLLC (J.B. Touma, M.D., J. Brett Chafin, M.D., Scott R. Gibbs, M.D., B. Joseph Touma, M.D.) for any service furnished to me by that physician. I authorize release to the Health Care Financing Administration and its agents any medical information about me to determine the payments for related services.