Rocky Mountain
Ear, Nose & Throat Center, P.C.

PATIENT INFORMATION Please Print

Patient ID# ____________

Patient's Name: ______________________________ (First / Initial / Last)
Date of Birth: ______________ Age: ________
Social Security #: ____________________ Sex: [ ]M [ ]F
Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed
Address: ______________________________
City, State, Zip: ______________________________
May we leave a message at any of these numbers? Yes No
County: ______________________________
Home Phone: ____________________ Other Phone: ________________ Work Phone: ______________
E-mail Address: ______________________________
Occupation: ______________________________ Employer: ________________ Phone: ____________
Referring Physician: ____________________________ Personal/Family Physician: ____________________
Spouse's Name: ______________________________

RESPONSIBLE PARTY INFORMATION *Adult accompanying minor (17 years of age or under) is responsible party*

Responsible Party: ______________________________
Birth Date: ______________________________ Social Security #: ____________________
Address: ______________________________ City, State, Zip: ____________________
Employer: ______________________________ Phone: ____________________

EMERGENCY CONTACT *Please give name and phone number of a friend or relative that does not live at your present address.*

Name: ______________________________ Phone: ______________________________
Relationship: ______________________________

Person(S) Who(M) We May Share Your Healthcare Information With: ______________________________

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name: ____________________	Insurance Name: ____________________
Subscriber Name: ____________________	Subscriber Name: ____________________
Subscriber ID#: ____________________	Subscriber ID#: ____________________
Date of Birth: ____________________	Date of Birth: ____________________
Group Number Certificate Number	Group Number Certificate Number

Insurance Authorization and Assignment
(Please read, sign and date)

I authorize Rocky Mountain Ear, Nose, & Throat Center, P.C. to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution and other healthcare operations to appropriate agencies, including collections agencies, insurance companies and third party payers.

I authorize treatment of the person named above, I certify that I am the patient or the legal guardian of the patient, and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless credit arrangements are made. I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable. The above information is for the purpose of extending credit and is warranted to be true. I have received a copy of "In Case of Errors or Inquires About Your Bill".

X______________________________ X________________
Patient / Responsible Party Signature Date