

TEXAS EAR, NOSE AND THROAT CONSULTANTS, PLLC

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____
Birthdate ____ / ____ / ____ Age ____ Sex ____ SS# ____ - ____ - ____ TDL # _____
Address _____, City _____, State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Occupation _____
Employer _____ Address _____
Marital Status _____ Spouse's Name _____
Referring Physician _____ City/State _____ Phone (____) _____

Emergency contact _____ Home Phone(____) _____
Relationship to patient _____ Work Phone (____) _____

FINANCIALLY RESPONSIBLE PARTY

Guarantor's Last Name _____ First Name _____ MI _____
DOB ____ / ____ / ____ SS # ____ - ____ - ____ TDL _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Occupation _____
Employer _____ Address _____

INSURANCE INFORMATION

(Please submit insurance card and driver's license for copying)

Primary Insurance _____
Claims Address _____
Insured's Name _____ ID# _____ Group # _____

Secondary Insurance _____
Claims Address _____
Insured's Name _____ ID# _____ Group # _____

“I hereby authorize Texas Ear, Nose & Throat Consultants, PLLC to provide any information associated with my care to my referring physician, other allied health professionals, or my insurance carrier.”

Patient/Guarantor signature _____ Date _____