Glacier Ear, Nose & Throat, Head & Neck Surgery

Patient Information						Appt Date:	
Account #:		Patient's SSN:					
First Name:		MI:		Last Name:			
Mailing Address:							
City:		State:		Zip:			
Date of Birth:		Age:		Sex:			
Marital Status:		Spouse's Name:					
Phone#	Home:		Work:		Cell:		

*Required Information For Minor Patients:					
Mother/Guardian:		Birthdate:		SSN:	
Address:		Phone#:			
Father/Guardian:		Birthdate:		SSN:	
Address:		Phone#:			
If not parent, who is accompanying child at this visit?					
Emergency contact name:		Phone No:		Relationship:	
Referring Physician's Name:		Referring Physician's Phone #:			

Insurance Information:					
Please present your insurance card(s) to the receptionist and give complete information below.					
Primary Insurance:		Insured's Name:			
Patient's Relationship to Insured:	☐ Self ☐ Spouse ☐ Child ☐ Other				
Policy#:		Group#:			
Employer:		SSN:		DOB:	
Secondary Insurance:		Insured's Name:			
Patient's Relationship to Insured:	☐ Self ☐ Spouse ☐ Child ☐ Other				
Policy#:		Group #:			
Employer:		SSN:		DOB:	

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and self-payment in full will be required at checkout.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature:		Date:	