SOUTHEAST TEXAS EAR, NOSE AND THROAT, L.L.P.
Welcome to Our Office

Date_____Dr. Seeing Today_____ Dr. That Sent You Here_____

Patient Name (Last)_____(First)_____(M)_____

Prefer Name_____Birthdate _____ Soc Sec #_____ □Male □Female

Race - □Amer.Indian/Alaska Native □Asian □Black/African Amer □Declined □Nat Hawaiian/Pacific Island □Other Race □Unknown □White

Ethnicity - □Declined □Hispanic or Latino □Not Hispanic or Latino □Unknown

Marital Status _____ Primary Language - □English □Spanish □Declined □Other_____

Address _____ City _____ State _____ Zip _____

Phone #: Home(____)_____ - Work(____)_____ - Cell(____)_____

Email_____

Employer _____ Telephone # (_____)_____

Emergency Contact not living with you _____ Relationship_____

Contact's Home Phone (_____)_____ Contact's Alternate Phone(____)_____

Associated Parties – You only need to complete this section:

If the Patient is a minor you should include info about the Mother, Father, Guardian, Stepparent, etc.

If the Patient is not the insured (the person that has the insurance plan) provide the info for that person

1) Relationship to Patient _____

Name (Last)_____(First)_____(M)_____

Preferred Name_____Birthdate _____ Soc Sec #_____ □Male □Female

Marital Status _____ Primary Language - □English □Other_____

Address _____ City _____ State _____ Zip _____

Phone #: Home(____)_____ - Work(____)_____ - Cell(____)_____ - Fax(____)_____ - Pager(____)_____ - Email_____

2) Relationship to Patient _____

Name (Last)_____(First)_____(M)_____

Preferred Name_____Birthdate _____ Soc Sec #_____ □Male □Female

Marital Status _____ Primary Language - □English □Other_____

Address _____ City _____ State _____ Zip _____

Phone #: Home(____)_____ - Work(____)_____ - Cell(____)_____ - Fax(____)_____ - Pager(____)_____ - Email_____

1st Insurance Company _____ Policy Holder _____

2nd Insurance Company _____ Policy Holder _____

I authorize the release of any medical information necessary to process this claim or provide continued medical care to a referring doctor/facility. I authorize payment of medical and surgical benefits to Southeast Texas Ear, Nose and Throat, LLP. I agree to be responsible for any payment not paid by my insurance due to lack of referral, deductible, co-insurance, pre-existing condition, etc. I consent to all services, treatment, and diagnostic procedures as ordered by my physician. I will notify the office of any insurance changes prior to treatment or surgery. This authorization will remain valid until I revoke it by written notice.

X_____ _____

Signature of Patient/Responsible Party Date

(ONLY PATIENT AGE 18+, PARENT OR LEGAL GUARDIAN MAY SIGN)