DEPENDENT-ADULT PATIENT INFORMATION SHEET

ENT & Audiology Center of Southlake

Phone: (817) 416-9731 Fax: (817) 416-9751

PATIENT

Date:	**Patient Name: (Last, First, Middle)**	DOB:	AGE:
Address:	City:	State:	Zip Code:
Home Phone:	Patient's SSN:		Sex:

Other family members treated? Yes ☐ No ☐ If Yes, Name(s) & Relationship:

Referred by PCP? Yes ☐ No ☐ **Referred by Someone other than PCP?** Yes ☐ If Yes, Name: **Not Referred** ☐

PCP Name:	Phone and Fax Numbers:	City of Practice:

RESPONSIBLE PARTIES

Permanent Residence is With: Father ☐ Mother ☐ Other ☐ Name-Relationship

Father Name: Last:	First:	Middle:	DOB:

Father's Address/Phone Same as Patient? Yes ☐ No ☐

If No: Father's Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:		SSN:
Employer:	Occupation:		Work Phone#
Mother's Name: Last	First	Middle	DOB:

Address/Phone Same as Patient? ☐ Yes ☐ No

If No: Mother's Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:		SSN:
Employer:	Occupation:		Emp. Phone#

PRIMARY INSURANCE

Is patient a fulltime student in secondary education on parent's insurance? Yes ☐ No ☐

Name of Insurance Company:	Id/Member #:	Group#:
Policy Holder's Name:	Policy Holder's DOB	Member/Cust. Svc. Ph #:
Referral Required by your Insurance company? Yes ☐ No ☐	If yes, did you obtain one from your PCP? Yes ☐ No ☐	

SECONDARY INSURANCE

If no secondary insurance, circle: NONE

Name of Insurance Company:	Policy Holder's Name:	Policy Holder's DOB
Id/Member #:	Group#:	Member/Cust Svc Ph #:

I hereby authorize my physician to release any information acquired in the course of my treatment to my insurance company, employer, or third party payer as required for claims filed, quality assurance, health plan administration, or complaints/grievances. I understand that the specific information to be released may include, but is not limited to history, diagnosis and/or treatment of all related illnesses including HIV virus and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to my physician for any and all medical or surgical services rendered. I understand that if any services or charges are not covered, or if ENT & Audiology Center of Southlake is unable to verify eligibility, that I am responsible for all charges incurred for services rendered. I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physician as may be necessary in his/her judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made to me as a result or cure. This form has been fully explained to me, and I certify that I understand its contents.

Signature & Relationship to Patient _____ Date _____