E.N.T. PHYSICIANS OF KEARNEY
and Family Hearing Center

PATIENT INFORMATION

Patient Name: _____ Sex (Circle One): Male Female

Date of Birth: _____ Social Security #:_____

Mailing Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell: _____ Work:_____

Guarantor/Family Email:_____

Employer: _____ Employer Address:_____

Marital Status (Circle One): Single - Married - Divorced - Widowed - Decline

Spouse name:_____ Spouse DOB: _____ Spouse SSN: _____

Is your condition a result of a work injury? Yes _____ No _____ Auto Accident? Yes _____ No _____ Date: _____

Preferred pharmacy: _____

RESPONSIBLE PARTY

☐ Check if the same as patient information

Person responsible for payment: _____ Date of Birth:_____

Relationship to patient: _____ SSN:_____

Address: _____ City: _____State: _____ Zip:_____

Phone: _____ Cell:_____

Employer:_____ Employer Phone: _____

Spouse name:_____ Spouse DOB: _____ Spouse SSN: _____

REFERRAL INFORMATION

Referring Physician: _____ Address: _____

Primary Care Physician: _____ Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient: _____ Phone: _____

Name**:** _____ Relationship to patient: _____ Phone: _____

GOVERNMENT MANDATED INFORMATION

Preferred language (Circle One): English - Spanish - Decline If Other, please specify: _____

Race (Circle One): White - Am. Indian - Black/African American - European - Japanese - Korean - Decline

Ethnicity (Circle One): Not Hispanic/Latino - Mexican/Hispanic/Latino - Cuban - Dominican - Puerto Rican - Decline

Contact Preference: Portal - Home Phone - Work Phone - Cell Phone - Mail

INSURANCE INFORMATION (Do not complete if insurance card is present)

Insurance Coverage: Yes ____ No ____ If no, how do you intend to pay? Cash ____ Check ____ Credit Card _____

Primary insurance: _____ ID Number: _____ Group: _____

Policy holder name: _____ DOB: _____

Secondary insurance: _____ ID Number: _____ Group: _____

Policy holder name: _____ DOB: _____

Please note that ENT Physicians of Kearney does NOT accept Kansas Medicaid plans

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ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA Privacy Policy for ENT Physicians of Kearney
- I hereby assign my insurance benefits to be paid directly to the healthcare provider
- I authorize ENT Physicians of Kearney to release medical information required to process my claim
- I have read and understand the Financial Policy for ENT Physicians of Kearney:
    - Our office will accept cash, personal checks, Visa, MasterCard, Discover and American Express credit cards. A statement of fees will be sent regularly. Regardless of medical insurance coverage, our clinic relies on you for settling your account. You are ultimately responsible for all clinic and surgery fees relating to your care. Your health insurance policy is an agreement between you and your health insurance carrier. Please be aware that some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance left unpaid by your insurance company. If you need to make special arrangements for payment, please contact our office manager.
- I authorize ENT Physicians of Kearney to obtain/have access to my medication history
- I authorize ENT Physicians of Kearney to contact me by mobile phone
- I authorize ENT Physicians of Kearney to contact me with information regarding hearing products
- I understand that ENT Physicians of Kearney does not accept Kansas Medicaid plans, and any expenses incurred are my responsibility
- I authorize the following individuals to access my medical information, including all billing and/or insurance transactions:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed: _____ Date: _____