Front Range ENT & Audiology

Patient Information

Today's Date: _______________

First Name: ________________________ MI: ______ Last Name: ________________________________

Address: ____

Zip Code: ___________________City: ___________________________ State: ______________________

Date of Birth: _____________ Marital Status: ___________ Sex: _________ SSN: ____________________

Home Phone: ___________________ Cell Phone: ___________________ Work Phone: __________________

In the event of an emergency please contact:

Name: ______________________________ Relationship: _________________ Phone: __________________

Who Referred You? Medical/Dental Provider Family/Friend Phone Book Internet Insurance Company Other ____

Referring Provider's Name: _______________________________ Phone No: ______________________

Primary Care Physician's Name: ___________________________ Phone No: ______________________

Insurance Information

Please present your insurance card(s) to the receptionist. Please fill out complete information.

Primary Insurance: __________________________ Policy Holder Name: ____________________________

Patient's Relationship to the Policy Holder: Self Spouse Child Other

Policy #: _______________________________________ Group #: ___________________________________

Employer: ______________________________ SSN: ________________________ DOB: _________________

Secondary Insurance: __________________________ Policy Holder Name: ___________________________

Patient's Relationship to the Policy Holder: Self Spouse Child Other

Policy #: _______________________________________ Group #: ___________________________________

Employer: ______________________________ SSN: ________________________ DOB: _________________

If we are seeing you for a Work Related Injury please fill out all of the following lines:

Date of injury: __________________ Carrier & Claim #: ____

Adjuster Name: ______________________________ Adjuster Phone No: ________________________________

Employer Name: ______________________________ Employer Phone No: ________________________________

Employer Address: ____

If we are seeing you for an Auto Related Injury please fill out all of the following lines:

Date of injury: __________________ Carrier & Claim #: ____

Adjuster Name: ______________________________ Adjuster Phone No: ________________________________

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 payment in full will be required. 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 or Parent/Guardian Signature: ____________________________________ **Date:** ______________

Guardian Name: ______________________________ Relationship to Patient: ____________________________

SSN: _______________________________________ Date of Birth: _____________________________________