Welcome To BENKE EAR NOSE & THROAT CLINIC!

***** **LEGAL GUARDIANS MUST ACCOMPANY "MINORS" UNDER 18 TO RECEIVE MEDICAL CARE**

Name: ____ Today's Date: ____________________
First Middle Last

Home Address: ____
City: ___________________________________ State: __________ Zip: _______________
Telephone: ( ) ____________________ Birthdate: _________________Age: ________
Male________ Female ________ Single _______ Married _______ Divorced ______Widowed ____
Email Address: _______________________________________
May we send information here? Yes No
Occupation: _______________________________________ SSN: ____________________________
Employer: ____ Years There: _____________
Employer's Address: ____
City: ___________________________________ State: __________ Zip: _______________
Work Phone: ( ) _______________________ Cell Phone: ( ) ____________________________

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____________________________________ Relationship to Patient: _________
Home Address: ____
City: ___________________________________ State: ____________ Zip: _____________
Telephone: ( ) ______________________ Birthdate: ____________________ Age:________
Occupation: ____ SSN:_______________________
Employer: ____ Years There: _____________
Employer's Address: ____
City: ___________________________________ State: __________ Zip: _____________
Work Phone: ( ) _______________________ Cell Phone: ( ) ____________________________

Name of Spouse: ____________________________ Birthdate: _______________ Age: _______
Occupation: ____ SSN: _________________________
Employer: ____ Years There: _____________
Employer's Address: ____
City: ___________________________________ State: __________ Zip: ______________
Employer's Telephone: ( ) ___________________ Cell Phone: ( ) _______________________

In case of emergency, contact: _________________________________ Relationship: ___________
Home Phone: ( ) ___________________________ Work Phone: ( ) ______________________
Were you referred by your primary care physician? Yes No
If yes, please list primary care physician's name ____
How did you learn about our practice? ____
May we contact you at work? Yes No
When is the best time to reach you? __________________

Insurance Information

Patient's Name:____ Today's Date:__________
First Middle Last

[Primary Insurance]
Name of Insurance Company: ____
Address: ____
City: ______________________________ State: _________ Zip: ______________
Insured's Name: _________________________________Date of Birth:_________________
Group Number: ______________________ Policy ID Number: ____________________

[Secondary Insurance]
Name of Insurance Company:
____
Address: ____
City: ______________________________ State: _________ Zip: ______________
Insured's Name: ___________________________Date of Birth:_______________________
Group Number: ______________________ Policy ID Number: ____________________

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts at the time of service.

Method of Payment for Today's Visit: ___Cash ___Check ___Credit Card

Signature of Patient or Responsible Party: ____

Date: ________________

I authorize the release of any medical information necessary to process my claim.

Signed: _______________________
(Patient or responsible party)

Date: ________________________

I authorize payment of medical and surgical benefits to
Benke Ear, Nose & Throat Clinic

Signed:______________________
(Patient or responsible party)

Date: ________________________