

ENT Clinic of Iowa, P.C.
1455 29th Street
West Des Moines, IA 50266

ENT Clinic of Iowa, P.C.
601 E. Locust St., Suite 201
Des Moines, IA 50309

PATIENT NAME: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Phone: () _____ Work Phone: () _____

Birth Date: _____ Age: _____ Social Security Number: _____

Sex: Male / Female (circle one) **Marital Status:** Married / Single / Other (circle one)

Patient's Employer: _____

Referring Physician: _____ Family Physician: _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Employer Phone: () _____

Emergency Contact (not at the same address): _____ **Phone:** () _____

INSURANCE INFORMATION

Primary Ins. Company _____

Secondary Ins. Company _____

Name of Cardholder _____

Name of Cardholder _____

ID / Policy #: _____

ID / Policy #: _____

Birth Date of Cardholder: _____

Birth Date of Cardholder: _____

SSN #: _____

SSN #: _____

Co-pay / Deductible: _____

Co-pay / Deductible: _____

COMPLETE THIS SECTION IF THE PATIENT IS A MINOR OR FULL TIME STUDENT

Student Status: **Full / Part time** (circle one)

Father's Name: _____ SSN#: _____ Birth Date: _____

Employer: _____ Work Phone#: () _____

Mother's Name: _____ SSN#: _____ Birth Date: _____

Employer: _____ Work Phone#: () _____

I authorize ENT Clinic of Iowa, P.C. to furnish information to insurance carriers concerning my illness and treatments and hereby assign the clinic all payments for services rendered to dependents or myself. I understand that I am responsible for amounts not covered by my insurance.

SIGNATURE: _____ **DATE:** _____