

Patient's Legal Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  Male  Female

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cellphone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Email Address \_\_\_\_\_

D.O.B. \_\_\_\_\_ Marital Status  M  S  D  W  Other \_\_\_\_\_

Spouse's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or other Pacific Islander  
 Caucasian  Hispanic or Latino

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Other \_\_\_\_\_ Preferred Language \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient's Legal Guardian (If Applicable) \_\_\_\_\_

Father's Name (IF MINOR) \_\_\_\_\_ D.O.B. \_\_\_\_\_

Father's Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Father's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name (IF MINOR) \_\_\_\_\_ D.O.B. \_\_\_\_\_

Mother's Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

**PRIMARY INSURANCE COMPANY NAME** \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Subscriber:  Self  Spouse  Parent  Child  Step Parent  Other

Subscriber D.O.B. \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE COMPANY NAME** \_\_\_\_\_ Phone \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Subscriber:  Self  Spouse  Parent  Child  Step Parent  Other

Subscriber D.O.B. \_\_\_\_\_ Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

**TREATMENT AUTHORIZATION**

I am willfully requesting treatment, and I consent to services provided by, or at the direction of, the attending provider at Southwest Idaho Ear Nose and Throat and Southwest Idaho Surgery Center. I authorize a copy of this document to be used in lieu of the original.

**PLEASE NOTE:** Physicians at Southwest Idaho ENT may need to perform additional testing, such as audiometric testing (hearing evaluations), nasal endoscopy, laryngoscopy, CT scans, biopsies and other diagnostic testing, including cerumen removal (ear cleaning), to accurately diagnose and treat the patient's condition. Each insurance policy processes these tests differently, and charges may be applied to the patient's deductible, co-insurance, co-pay or non-covered benefit, which may result in a separate charge to an office visit fee.

Please Initial \_\_\_\_\_ NOTICE OF PRIVACY PRACTICES: As required by law, I have been offered a copy of the Notice of Privacy Practices followed by Southwest Idaho ENT and Southwest Idaho Surgery Center.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Relation to Patient