MACE L. BRINDLEY, M.D.
JAMES R. TANDY, M.D.
ANDREW J. LEHR, M.D.
BRADFORD W. HOLLAND, M.D.

Welcome To Our Office

WACO EAR, NOSE & THROAT

OTOLARYNGOLOGY
HEAD AND NECK SURGERY
NASAL ALLERGY

FORM MUST BE COMPLETELY FILLED OUT
(Please Print)

OFFICE USE ONLY	VERIFIED INITIALS:___________ VERIFIED DATE:___________

Home Ph: ________________ Cell Ph: ______________ Date: ________________

CHILD INFORMATION
(If under 18 yrs. old)

Name: ____
Last First Middle

Child SS #: ______/______/______ Date of Birth: ______/______/______ Age: ______ Sex: ______

Address ____
Street City State Zip

FATHER/GUARDIAN INFORMATION

Name: ______________________________ Relationship to Patient ______________
Last First Middle

SS #: ______/______/______ Date of Birth: ______/______/______ Age: ______

Address if different from above: ______________________________

Employer: ______________________________ Occupation: ______________

Address ______________________________ Phone: ______________
Street City State Zip

MOTHER/GUARDIAN INFORMATION

Name: ______________________________ Relationship to Patient ______________
Last First Middle

SS #: ______/______/______ Date of Birth: ______/______/______ Age: ______

Address if different from above: ______________________________

Employer: ______________________________ Occupation: ______________

Address ______________________________ Phone: ______________
Street City State Zip

IN CASE OF AN EMERGENCY NOTIFY (not living with you - preferrably local):

Name: ______________________________ Phone: ______________

Relationship to patient: ______________________________

Allergies to Medication: ______________________________

Referring Physician: ______________________________ Phone: ______________
(required) Last First

Address: ______________________________
Street City State Zip

Personal Physician: ______________________________ Phone: ______________
Last First

Address: ______________________________
Street City State Zip

Waco Ear, Nose & Throat requires payment in full of all patient responsibility balances on the date service is rendered. This includes uninsured balances, non-covered items, insured co-payments, and deductibles. Please indicate your method of payment:

☐ Cash ☐ Check ☐ Money Order **Credit Card:** ☐ Visa ☐ Mastercard ☐ Discover

(OVER)

INSURANCE INFORMATION-Please provide forms for photocopying - Primary

Insured's Name____Relation to Patient_______________________

Home Phone_____________________________________Work Phone______________________________________

Birthdate____Social Security Number______________________________

Primary Insurance:_________________________________ Policy #______________________ Group #____________

Address:____Phone #________________

Street City State Zip

INSURANCE INFORMATION-Please provide forms for photocopying - Secondary

Insured's Name____Relation to Patient_______________________

Home Phone_____________________________________Work Phone______________________________________

Birthdate____Social Security Number______________________________

Secondary Insurance:______________________________________Policy #________________ Group #______________

Address:____Phone #________________

Street City State Zip

Consent to Treat

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowlegde that no representations, warranties or guarantees as to the results or cures have been made to me.

Assignment of Benefits

I hereby assign directly to Waco Ear, Nose & Throat all medical insurance benefits, if any, payable for services rendered. I ultimately understand that I am financially responsible for all charges. I understand the details of my insurance plan, and agree to comply with them. I understand that my portion of payment (including co-pays) are due on or prior to the day service is rendered. I here by authorize the physician to release any medical or other information to my insurance carrier.

____ ___________________________

Signature of Parent/Guardian Date