Mid-Kansas Ear, Nose & Throat Associates
A Division of Wichita Surgical Specialists, P.A.

APPT DATE:______________________________

APPOINTMENT WITH: ☐ *DR. KUBINA* ☐ *DR. THAKOR* ☐ *DR. BUNTING* ☐ *MARK MANNNING PA-C*
☐ *DR. STUMPE* ☐ *DR. DE LA GARZA* ☐ *DR. HAWLEY* ☐ *CHRISTY SIDWELL APRN*

PATIENT INFORMATION

PATIENT NAME ____ **SOCIAL SECURITY #**____________________
Last First Middle Initial

ADDRESS ____
Street City State Zip

DATE OF BIRTH ______________ **AGE** ______ **EMPLOYER**______________________**EMAIL:**______________________

SEX ☐ Male ☐ Female

MARITAL STATUS ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed

RACE ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Hawaiian or Pacific Islander ☐ Other Race______________

ETHNICITY ☐ Non Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

PREFERRED LANGUAGE ☐ English ☐ Spanish ☐ Other____________

HOME PHONE______________________

WORK PHONE______________________

CELL PHONE______________________

SPOUSE OR GUARDIAN

NAME ____ **SOCIAL SECURITY #**____________________
Last First Middle Initial

ADDRESS ____ **EMPLOYER** ____________________
(if different than patient's) Street City State Zip

DATE OF BIRTH ______________ **RELATIONSHIP TO PATIENT** ____________________ **EMAIL**______________________

HOME PHONE______________________

SEX ☐ Male ☐ Female

MARITAL STATUS ☐ Never Married ☐ Divorced ☐ Married ☐ Widowed

WORK PHONE______________________

CELL PHONE______________________

SPOUSE OR GUARDIAN

NAME ____ **SOCIAL SECURITY #**____________________
Last First Middle Initial

ADDRESS ____ **EMPLOYER** ____________________
(if different than patient's) Street City State Zip

DATE OF BIRTH ______________ **RELATIONSHIP TO PATIENT** ____________________ **EMAIL**______________________

HOME PHONE______________________

SEX ☐ Male ☐ Female

MARITAL STATUS ☐ Never Married ☐ Divorced ☐ Married ☐ Widowed

WORK PHONE______________________

CELL PHONE______________________

EMERGENCY CONTACT

NAME (person not living with you) ______________________________________ **RELATIONSHIP**____________________
Last First Middle Initial

HOME PHONE ____________________ **WORK PHONE** ____________________ **CELL PHONE** ____________________

INSURANCE INFORMATION

PRIMARY INSURANCE ____ **POLICY #** ____________________

POLICY HOLDER ____ **SOC SEC #**____________________
Last First First Middle Initial

ADDRESS ______________________________________ **EMPLOYER** ____________________
(if other than above) Street City State Zip

DATE OF BIRTH ______________ **RELATIONSHIP TO PATIENT** ____________________ **POLICY EFFECTIVE DATE**______________

SECONDARY INSURANCE ____ **POLICY #** ____________________

POLICY HOLDER ____ **SOC SEC #**____________________
Last First First Middle Initial

ADDRESS ______________________________________ **EMPLOYER** ____________________
(if other than above) Street City State Zip

DATE OF BIRTH ______________ **RELATIONSHIP TO PATIENT** ____________________ **POLICY EFFECTIVE DATE**______________

REFERRAL SOURCE:

☐ PHYSICIAN ____
Last Name First Name Address / City

☐ FRIEND ☐ PHONE BOOK ☐ INTERNET ☐ OTHER ______________________

FAMILY PHYSICIAN:

(if other than referring) ____
Last Name First Name Address / City

IMPORTANT: PLEASE READ THE INFORMATION ON THE BACK OF THIS SHEET. YOUR SIGNATURE IS REQUIRED.

RELEASE OF INFORMATION

I authorize Mid-Kansas ENT to release any information to any physician involved in my care, hospital, and/or my insurance company including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical and Surgical care.

ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance benefits directly to Mid-Kansas ENT, Division of Wichita Surgical Specialists, P. A. otherwise payable to me. I further certify I have provided Mid-Kansas ENT a complete list of the insurance companies with which I have Medical and/or Surgical coverage.

FINANCIAL AGREEMENT & OFFICE POLICY

I understand that my insurance policy may pay less than the actual charges for services. I understand I am financially responsible for payments in full of all co-payments, coinsurance and deductibles as specified by my insurance plan. If payment is denied or If payment is denied or not covered by my insurance, or if I have no insurance, I agree to be responsible for payment in full. I have received a copy of the Office Policy.

PATIENT NAME (please print) ______________________________

SIGNATURE ______________________________ **DATE** ______________
(PATIENT OR GUARDIAN IF PATIENT IS A MINOR)

ATTENTION MEDICARE PATIENTS

**** TO BE COMPLETED FOR ALL MEDICARE PATIENTS ****

PATIENT NAME ______________________________ DATE OF SERVICE______________

(If answer is YES to any of the following questions 1 through 4, the cooresponding section of the "Other Insurance" form must be completed.)

	YES	NO
1. Is the patient a Veteran	☐	☐
a. Did the VA refer patient here for treatment?	☐	☐
b. Does the patient have a VA "fee basis ID card"?	☐	☐
2. Do you have a Federal Black Lung card?	☐	☐
3. Is this medical condition due to an accident of any kind?	☐	☐

If yes, was it:

☐ Work related ☐ Auto

☐ Injured in own home ☐ Other ______________

	YES	NO
4. Is the patient covered by an employer's health insurance plan through either their own employment or that of a family member? (Not retiree coverage)	☐	☐

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits made either to me or on my behalf to Mid-Kansas Ear Nose & Throat A Division of Wichita Surgical Specialists, P. A. for any services provided to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

PATIENT'S SIGNATURE ______________________________ **DATE** ______________