

Mid-Kansas Ear, Nose & Throat Associates

A Division of Wichita Surgical Specialists, P.A.

APPOINTMENT WITH: DR. KUBINA DR. THAKOR
 DR. HAWLEY DR. LE

APPT DATE: _____
 DR. BUNTING DR. STUMPE DR. DE LA GARZA
 MARK MANNING PA-C CHRISTY SIDWELL APRN TENNILLE GREB, APRN

PATIENT INFORMATION

PATIENT NAME _____ SOCIAL SECURITY # _____
Last First Middle Initial

ADDRESS _____
Street City State Zip

DATE OF BIRTH _____ AGE _____ EMPLOYER _____ EMAIL: _____

SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	RACE <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> Other Race _____	ETHNICITY <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown	HOME PHONE _____
MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		PREFERRED LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	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 _____

SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	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 _____

SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	HOME PHONE _____
		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 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 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 YES NO
 - a. Did the VA refer patient here for treatment? YES NO
 - b. Does the patient have a VA "fee basis ID card"? YES NO
- 2. Do you have a Federal Black Lung card? YES NO
- 3. Is this medical condition due to an accident of any kind? YES NO

If yes, was it:

 - Work related Auto
 - Injured in own home Other _____
- 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) YES NO

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 _____