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

APPT DATE:_____

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_____

COMMUNICATION PREFERENCE (please check all that apply):

Cell Phone: □ Phone Call □ Text □ Leave Message **Home Phone:** □ Phone Call □ Leave Message **Work Phone:** □ May use to contact patient

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 ☐ Married ☐ Divorced ☐ 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 ☐ Married ☐ Divorced ☐ Widowed

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.

HIPAA ACKNOWLDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that a copy of the Mid-Kansas Ear, Nose & Throat, Division of Wichita Surgical Specialists, PA's Notice of Privacy Practices will be provided upon request.

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 _____

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** _____