Eastern Oklahoma Ear, Nose & Throat

Patient's Last Name: ______________________________ **First Name**: _______________________________ **Middle Initial**: ______

SSN#: ______________________ **Date of Birth**: _____________ **Age**: __________ **Sex**: ☐ Female ☐ Male

Address: __________________________________ **Apt. #**_________ **City**: __________________ **State**: _________ **Zip**:_________

Home Phone: _____________________________ **Day Phone**: ___________________________ **Cell Phone**: ___________________

Alternate Contact: Name: _________________________________**Phone**: ___________________**Relationship**: ___________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of Primary Care (Family) Physician /Pediatrician (**First and Last Name of PCP**): ____

Referring Physician Name (**First and Last Name of Referring Dr. if different**): ____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian Other ___________________**Language**: ______________________________

Ethnicity: ☐ Hispanic ☐ Non Hispanic **E-mail Address**: ____

Responsible Party Please list both parents/guardians if the patient is a child.

Name: ____

Relationship: _______________________________________

Birthdate: _________________ SSN# _____________________

Address: ____

City/State/Zip: _______________________________________

Cell Phone: ____

Employer: ____

Home Phone: (_______)___________________________________

Work Phone: (_______)____________________________________

Primary Insurance: ___________________________________

Insurance Company: ___________________________________

Policy Holder: ____

Policy Holder DOB: ____________________________________

I.D.#: ____________________ Group:_____________________

Employer: ____

Name: ____

Relationship: _______________________________________

Birthdate: _________________ SSN# _____________________

Address: ____

City/State/Zip: _______________________________________

Cell Phone: ____

Employer: ____

Home Phone: (_______)___________________________________

Work Phone: (_______)____________________________________

Secondary Insurance:**___________________________________**

Insurance Company: ___________________________________

Policy Holder: ____

Policy Holder DOB: ____________________________________

I.D.#: ____________________ Group:_____________________

Employer: ____

I hereby assign to Eastern Oklahoma Ear, Nose, & Throat Inc., any and all rights and interest in insurance benefits and direct that all such payments be made directly to the clinic. I understand that I am financially responsible for all deductibles, coinsurance and all services not covered by insurance benefits and/or entitlements.

Eastern Oklahoma Ear, Nose, & Throat, Inc. physicians have a financial interest in Tulsa Spine & Specialty Hospital, LLC, (TSSH). Your physician may refer you to the TSSH facility where medical procedures may be performed. The Oklahoma Financial Disclosure Statute requires that we inform you of your physician's financial interest in Tulsa Spine& Specialty. I acknowledge the disclosure, and authorize any holder of information about me to release to the health plan indicated, and information needed to determine these benefits payable to related services.

Signature: ____Date: _______________________________________