SOUTHWEST IDAHO ENT
Ear Nose and Throat, P.A.

Patient's Legal Name: First _____ Middle _____ Last _____ ☐ Male ☐ Female
Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____ Cellphone _____ Work Phone _____ Ext. _____
Email Address _____
D.O.B. _____ Marital Status ☐ M ☐ S ☐ D ☐ W ☐ Other _____
Spouse's Name _____ D.O.B. _____
Primary Care Physician _____ Referring Physician _____
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ Caucasian ☐ Hispanic or Latino
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____ Preferred Language _____
Patient's Employer _____ Work Phone _____
Patient's Legal Guardian (If Applicable) _____

Father's Name (IF MINOR) _____ D.O.B. _____
Father's Home Address _____ City _____ State _____ Zip _____ Phone _____
Father's Employer _____ Occupation _____ Work Phone _____
Mother's Name (IF MINOR) _____ D.O.B. _____
Mother's Home Address _____ City _____ State _____ Zip _____ Phone _____
Mother's Employer _____ Occupation _____ Work Phone _____

PRIMARY INSURANCE COMPANY NAME _____ Phone _____
Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other
Subscriber D.O.B. _____ Subscriber # _____ Group # _____
SECONDARY INSURANCE COMPANY NAME _____ Phone _____
Subscriber Name _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Step Parent ☐ Other
Subscriber D.O.B. _____ Subscriber # _____ Group # _____

TREATMENT AUTHORIZATION

I am willfully requesting treatment, and I consent to services provided by, or at the direction of, the attending provider at Southwest Idaho Ear Nose and Throat and Southwest Idaho Surgery Center. I authorize a copy of this document to be used in lieu of the original.

PLEASE NOTE: Physicians at Southwest Idaho ENT may need to perform additional testing, such as audiometric testing (hearing evaluations), nasal endoscopy, laryngoscopy, CT scans, biopsies and other diagnostic testing, including cerumen removal (ear cleaning), to accurately diagnose and treat the patient's condition. Each insurance policy processes these tests differently, and charges may be applied to the patient's deductible, co-insurance, co-pay or non-covered benefit, which may result in a separate charge to an office visit fee.

Please Initial _____ NOTICE OF PRIVACY PRACTICES: As required by law, I have been offered a copy of the Notice of Privacy Practices followed by Southwest Idaho ENT and Southwest Idaho Surgery Center.

_____ _____
Signature of Patient or Legal Guardian Date Signed

_____ _____
Printed Name of Patient or Legal Guardian Relation to Patient