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Panhandle Ear Nose & Throat
3501 South Soncy Road, Suite 140
Amarillo, Texas 79119
806-355-5625 phone
806-352-2245 fax

MR # _____

PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Initial
Patient Social Security Number	Patient Date of Birth and Age	Patient Sex
		Male Female Other
Patient Street Address with Apt. Number	PO Box Number (if applicable)	City, State, Zip
Patient Race	Ethnicity	Contact Preference
African American Hispanic Multi-Racial White Other :_____	Hispanic Non-Hispanic Declined to Specify	Home Number Cell Number Text E-Mail
Patient Marital Status	Patient Primary Care Physician	Patient Home Phone
Divorced Domestic Partner Life Partner Married Separated Single Widowed		
Patient Day Phone	Patient Cell Phone	Patient E-Mail
Patient Employer	Patient Employer Address	Patient Employer Phone

RESPONSIBLE PARTY (RP) INFORMATION

RP Last Name	RP First Name	RP Middle Initial
RP Social Security Number	RP Date of Birth and Age	RP Sex
		Male Female
RP Mailing Address	City, State, Zip	RP Home Phone
RP Day Phone	RP Cell Phone	RP E-Mail
RP Employer	RP Employer Address	RP Employer Phone

PRIMARY INSURANCE INFORMATION – PLEASE PROVIDE A CURRENT COPY OF YOUR INSURANCE CARD

Insurance Name	Policy Number	Group Number
Remit Claims to Address – PO Box Number	City, State, Zip	Insurance Phone Number
Subscriber Name (who carries the Insurance)	Subscriber Date of Birth Subscriber Sex	Subscriber Social Security Number
	Male Female	

SECONDARY INSURANCE INFORMATION - PLEASE PROVIDE A CURRENT COPY OF YOUR INSURANCE CARD

Insurance Name	Policy Number	Group Number
Remit Claims to Address – PO Box Number	City, State, Zip	Insurance Phone Number
Subscriber Name (who carries the Insurance)	Subscriber Date of Birth Subscriber Sex	Subscriber Social Security Number
	Male Female	

MR # _____

Patient Last Name	Patient First Name	Patient Middle Initial

ADDITIONAL INFORMATION

Emergency Contact Name	Relationship to Patient	Emergency Contact Name Phone Number(s)
Emergency Contact Name	**Relationship to Patient**	**Emergency Contact Name Phone Number**

HIPAA INFORMATION

Panhandle Ear, Nose & Throat and Baptist St. Anthony's Physicians Group, Inc. (BSAPG) complies with HIPAA regulations; therefore we require that you complete the following section. Please understand that we can only share information with the person(s) and/or organization(s) that you list. Any person(s) and/or organization(s) that are not listed can only receive information after the patient or the patient's responsible party has signed a release of information form. The list below will be considered valid for a period of year (1) year unless a written request is received by the patient or the responsible party revoking consent.

Name	Date of Birth	Phone Number
Address	Relationship	Alternate Phone Number
Name	Date of Birth	Phone Number
Address	Relationship	Alternate Phone Number

According to the Texas Family Code 35.01 - states, a minor must be accompanied by a parent for treatment, unless one of the following applies to the patient. 1) the minor is on active duty with the armed forces of the USA. 2) the minor resides apart from his/her parents and manages their own financial affairs. 3) the minor has a disease which is reportable to Texas Department of Health. 4) the minor who is married and pregnant. 5) the minor is seeking treatment for an addiction. 6) the minor is seeking treatment for counseling such as suicide prevention, chemical addition or dependency or sexual, physical or emotional abuse. If you are a minor and one of the above do not apply, you must be accompanied by a parent.

I request that insurance benefits be made on my behalf to Panhandle Ear, Nose & Throat and BSAPG for any services furnished to the patient or dependent(s). I authorize and understand that Panhandle Ear, Nose & Throat and BSAPG holder of medical information about the patient or dependent(s) to release to the insurance carrier(s) any information needed to determine the benefits payable on any services to the patient or dependent(s). I understand that a photocopy of this assignment is to be considered as valid as the original until revoked by the patient or responsible party in writing. **I UNDERSTAND THAT I AM FINANCIAL RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE CARRIER(S).**

I have read and understand the above statements.

Patient or RP Signature Date