# Indiana Ear & Sinus Institute

## PERSONAL INFORMATION

Name: ________________________________ ____________________________ _______
(Last) (First) (Middle Initial)
Address: ________________________________________ Age: ___________ Sex: M F

City: __________________________ State: ____________ Zip Code: __________________

Social Security #: _________________ Marital Status:__________________ DOB:___________

Phone number: __________________________________ Cell Phone: ______________________________

Name of Parent/Guardian:______________________________________________________________

E-mail address:_______________________________________________________________________

Emergency contact not living with you: ____________________ Phone #: ___________________________

Requesting Physician Name:_______________________________________________________________

Physicians Address and phone number:_______________________________________________________

Pharmacy Name:_______________________________________________________________________

Pharmacy Address and phone number:________________________________________________________

## INSURANCE INFORMATION

Primary Insurance:_____________________________ Insured's Name_____________________________

Policy #_____________________________________ Group #_________________________________

SSN:________________________________________ DOB:_______________________________________

Secondary Insurance:__________________________ Insured's Name_____________________________

Policy #_____________________________________ Group #_________________________________

SSN:________________________________________ DOB:_______________________________________

## NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance and payment in full will be required.
Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit an, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurances may apply.
For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature_________________________________________ Date:_____________________________________