ST. JOSEPH'S EAR, NOSE AND THROAT CLINIC
THOMAS R. deTAR, M.D., F.A.C.S.

Patient Name:____ Sex:_________ Date of Birth:______________
Last, First, Middle

Social Security #:___________________________________ Single Married Widowed Separated Divorced

Address:____________________________________ City/State:_____________________________ Zip:__________

Home Phone:_____________________ Cell Phone:______________________ Work Phone: ____________________

Employer:_______________________________ Address:____

Parent(s) or Guardian(s):

Mother:____ DOB:_______________________
Last, First, Middle

Address:____________________________________ City/State:_____________________________ Zip:__________

Social Security #:_______________________ Home Phone:_____________________ Work Phone:________________

Employer:_______________________________ Address:____

Father:____ DOB:_______________________
Last, First, Middle

Address:____________________________________ City/State:_____________________________ Zip:__________

Social Security #:_______________________ Home Phone:_____________________ Work Phone:________________

Employer:_______________________________ Address:____

Emergency Contact:___________________________ Relationship:_________________ Phone:__________________

Name of your primary care physician:___________________________ Referring physician:________________________

Please read the following statements and initial if you give your permission:

________ I give my permission to discuss my health information with the following individual(s): Spouse____________________

________ I give my permission to leave messages on my answering machine at home regarding appointments, routine tests results and prescriptions.

________ I give my permission to call me at work.

To the best of my knowledge, all of this information is true and complete. I understand that I am responsible to pay for all services rendered to me and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. (PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE PHYSICIAN AND IS NOT A SUBSTITUTE FOR PAYMENT.)

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to me or my dependent. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature (RESPONSIBLE PARTY):____
Date:___________________________

MEDICARE ASSIGNMENT/SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made directly to St. Joseph's Ear, Nose & Throat Clinic, for any service provided me by Thomas R. deTar, M.D., F.A.C.S. I authorize St. Joseph's Ear, Nose & Throat Clinic, to release information to HCFA and its agents any information needed to determine benefits.

Signature (RESPONSIBLE PARTY):____
Date:___________________________