THE EAR, NOSE & THROAT CENTER, AMC

2121 Line Avenue ♦ Shreveport, LA 71104-2126
8575 Fern Avenue #103 ♦ Shreveport, LA 71105

PATIENT INFORMATION SHEET

- ☐ Robert S. Thornton, M.D., FACS
- ☐ David G. Pou, M.D.
- ☐ Henry J. Hollier, M.D.
- ☐ William H. Watkins, M.D.
- ☐ Blake N. Thornton, M.D.

Demographic Information:

Patient's Name: _____ **DOB:** _____ **Sex:** ☐ M ☐ F
Last First Middle

SSN: _____ **Race:** _____ **Are you of Hispanic/Latino descent?** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Email Address: _____ **Please contact me by:** ☐ Home # ☐ Work # ☐ Cell # ☐ Email

Preferred Local Pharmacy:

Name of Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Approximate Location (cross streets, city, etc.): _____

Emergency Contact:

Nearest Friend or Relative (not living with patient): _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Relation to Patient: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employment:

Guarantor's Employer: _____ **Guarantor's Work #:** _____

Family Data: (Complete only if patient is a minor child.)

Father's Name: _____ **Mother's Name:** _____

DOB: _____ **DOB:** _____

Address: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **City:** _____ **State:** _____ **Zip:** _____

Responsible Party: (Person responsible for payment after insurance, if not patient.)

Last Name: _____ **Sex:** ☐ M ☐ F **DOB:** _____

First Name: _____ **Relation to Patient:** _____

Address: _____ **SSN:** _____

City: _____ **State:** _____ **Zip:** _____ **Home #:** _____ **Work #:** _____

- Turn Page Over -

INSURANCE REFERRALS OR PRIOR AUTHORIZATIONS ARE THE RESPONSIBILITY

OF THE PATIENT OR THEIR RESPONSIBLE PARTY.

DEDUCTIBLES AND CO-PAYS ARE DUE AT THE TIME OF SERVICE.

Insurance Information: (Please present insurance cards and picture ID at check-in.)

Primary Insurance:

Policy Owner/Subscriber: **DOB:**

Policy ID: **Group #:**

Relation to Patient:

Secondary Insurance:

Policy Owner/Subscriber: **DOB:**

Policy ID: **Group #:**

Relation to Patient:

Please be advised that we do not hold insurance companies responsible for payment. PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.
Person responsible for payment is the person bringing the child in for treatment.

Date: **Signature:**

Provider Information

Referring Physician:

Address:

Phone Number:

Who referred you to us?

Primary Care Physician:

Address:

Phone Number:

I hereby authorize The Ear, Nose & Throat Center, AMC to furnish information concerning my illness and treatments to insurance carriers, physicians/healthcare personnel and my spouse. I also allow the ENT Center to retrieve all healthcare information from my providers(Physicians, Pharmacy, Labs, Hospitals, etc.). I grant assignment to the physician(s) for all payments for services rendered to myself or my dependents. I accept responsibility for any amount incurred including attorney and collection fees, if applicable. I have reviewed a copy of this office's Notice of Privacy Practices.

SIGNED: **DATE:**

DATE:

DATE:

DATE:

I authorize my physician and the employees of this clinic to speak with:

Person: Relationship:

Phone number(s):

_____ Account/Bill _____ Test Results _____ Medical Care _____ ALL