

**Registration :**

**Lone Star Ear Nose And Throat Care, PA**

Date	Account ID	Chart ID	Other ID	Internal Use
------	------------	----------	----------	--------------

**Patient Information**

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #
Address			Home:	How did you hear of us?			
Address 2			Work:				
			Cell:				
			Email:				
City	State	Zip Code	Employer Name & Address			Occupation	
Emergency Contact		Phone	Pharmacy			Pharmacy Phone	

<b>Physician</b>	<b>Family Physician</b>	<b>Referring Physician</b>
------------------	-------------------------	----------------------------

Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

**Guarantor (Person to be billed, if different than patient)**

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:	Work:	Email:	
City	State	Zip Code	Employer Name & Address			Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
Address			Home:	Work:	Email:	
City	State	Zip Code	Employer Name & Address			Occupation

**HIPAA Approved Contacts**

1 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell: Work:
2 Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship
Address		City	State	Zip Code	Home:	Cell: Work:

**Patient's or Authorized Person's Signature**

I have read, understand, and agree to the financial policy for Lone Star Ear, Nose, and Throat Care. I agree that charges not covered by my insurance company and all applicable copayments and deductibles are my responsibility. I understand that payment is due at the time of service. I hereby give my consent to be examined and treated.  
 I assign directly to Lone Star Ear, Nose, and Throat Care, or Dr. Mark Bickert, all medical benefits otherwise payable to me for services rendered. I authorize Lone Star ENT to release all information necessary to secure payment of benefits and to use my signature on all my insurance submissions.  
 I acknowledge receipt of the Notice of Privacy Practices.

Signature	Signature Date	<b>Lone Star Ear Nose And Throat Care, PA</b> 4100 Fairway Court, Suite 100 Carrollton, TX 75010 Phone: 972-939-0368 Email:
X		

Please attach all pertinent insurance ID cards for photocopying.