

Lone Star ENT Specialists, PA
 Patient Registration Information
Please complete each field in it's entirety.

Patient's Last Name:		Patient's First Name & Middle Initial		Sex: M or F
Date of Birth: / /	Age:	SS# - REQUIRED - -	Marital Status: ___Single ___Married ___Divorced ___Widowed	
Street Address:			Apt #:	City, State, Zip
Home Phone #: () -	Work Phone #: () -	Cell Phone #: () -	Texas Driver's License #:	
Employer/School:			Email:	

If The Patient Is A Minor

Father's Name: _____ Father's SS# / DOB: _____ Father's Driver's License #: _____ Place of Employment: _____	Mother's Name: _____ Mother's SS# / DOB: _____ Mother's Driver's License #: _____ Place of Employment: _____
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Insurance Information

Primary Insurance: _____ Policy #: _____ Group #: _____ Name of Insured: _____ Insured's DOB: _____ Insured's Social Security #: _____ Relationship to Insured: _Self _Spouse _Child _Other	Secondary Insurance: _____ Policy #: _____ Group #: _____ Name of Insured: _____ Insured's DOB: _____ Insured Social Security #: _____ Relationship to Insured: _Self _Spouse _Child _Other
Name of Family Doctor: _____ Ph# _____	

Referring Doctor:	Reason for Today's Visit:
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Name of Pharmacy:	Emergency Contact:	Phone #:	Relationship:
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I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lone Star ENT Specialists, PA, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Date: _____ Your Signature: _____

