



ENT MEDICAL SERVICES
 SLEEP CENTER, PLC
 2901 Northgate Drive
 Iowa City, IA 52245
 319.338.2101 / 319.338.1973 Fax

Date: _____

Patient's Name: _____
 (last) (legal first) (middle initial)
 Age: _____ Date of Birth: _____ Sex: M F S M W D
 (marital status)

Street Address: _____
 City: _____ State: _____ Zip: _____

Home Phone: () Student Status: _____

Cell Phone: () Social Security # (patient): _____

Spouse: Social Security # (spouse): _____

Employer (self): Employer Phone #: _____

Employer (spouse): Employer Phone #: _____

If patient is a minor: Child resides with: (circle) Mother Father Both Other: _____

FILL OUT PARENT INFORMATION BELOW IF THE PATIENT IS A MINOR OR DEPENDANT COLLEGE STUDENT

Father: Social Security #: _____

Mother: Social Security #: _____

Address: (If different than above): _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer Father: Employer Phone #: _____

Employer Mother: Employer Phone #: _____

Have you or immediate family members been seen by our doctors before: Yes No

Who shall we contact in an emergency?: _____

Relationship: Phone #: _____

Referring Doctor: Family Doctor: _____

Primary Insurance Company: _____
 (Subscriber's Name) (Policy #) (Subscriber's Birth Date)

Secondary Insurance Company: _____
 (Subscriber's Name) (Policy #) (Subscriber's Birth Date)

It is your responsibility to determine if our services are covered under your insurance plan. I understand that I am financially responsible for all charges whether or not paid by insurance and that interest will be charged at a rate of 1.5% per month on balances over 60 days. I authorize the doctor to release all information necessary to secure the payment of insurance benefits. I authorize insurance payment of medical benefit to ENT MEDICAL SERVICES SLEEP CENTER, PLC.

X
 Signature Date Relationship (if not signed by patient)

I wish to place the following restrictions of disclosure of my health information:

HIPPA
 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES
 (TO BE FILED IN THE PATIENTS MEDICAL RECORDS)
 I have been presented with a copy of the NOTICE OF PRIVACY PRECITES, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

X DATE: _____
 Signature of patient

Relationship (if not signed by patient)

I wish to place the following restrictions of disclosure of my health information:

INTERNAL USE ONLY
 If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to the patient and sign below:
 PRESENTED ON / / BY (NAME AND TITLE): _____