Philip A. Scolaro, M.D.
David W. Cuthbertson, M.D.
Otolaryngology
Head and Neck Surgery

EAR NOSE & THROAT
ASSOCIATES OF LUBBOCK

Cathy M. Thackrey, Au.D., CCC-A
Audiology
Hearing Aids

PATIENT INFORMATION (ADULT)

Chart: ____________

**EMAIL COMPLETED FORMS TO: SCHEDULING@ENTLUBBOCK.COM

Last Name | First Name | Middle Name | Suffix

Date of Birth | male | female | Marital Status | SS# | Preferred Language (s)

Street / Mailing Address | City | State | Zip Code

Home Phone (with Area Code) * indicate if primary | Cell Phone (with Area Code) * indicate if primary | Work Phone (with Area Code) *indicate if primary

May we contact you via email? No Yes Email address: ____________

Employer | Occupation

Employer's Street Address | City | State | Zip

Race: Native American/Alaskan Asian Black Caucasian Pacific Islander Other Declined

Ethnicity: Hispanic Non-Hispanic Declined

Spouse or Insured Last Name (Insured if under parent's insurance) | First Name | Middle Name

Address (if different than above) | City | State | Zip Code

Date of Birth | SS# | Cell Phone (with Area Code) | Work Phone (with Area Code)

Employer | Indicate relationship to policyholder if applicable (i.e. self, spouse, child, other...)

Allergies to Medications

Referring Physician | Phone (with Area Code)

Family/Primary Physician | Phone (with Area Code)

Pharmacy | Location | Phone (with Area Code)

Emergency Contact Other Than Spouse | Relationship | Phone (with Area Code)

Payment of Fees: Necessary forms will be completed to help expedite insurance carrier payment to our office. By signing this form, I indicate that I understand my patient responsibility as outlined in the Ear Nose and Throat Associates Financial Policy (copy available at www.entlubbock.com or upon request). Fees are due and payable at the time services are rendered, unless other arrangements have been made in advance with our office manager. I also understand that my account may be referred to collections if balances are not paid in full.

Insurance Authorization & Assignment: I hereby authorize Ear Nose & Throat Associates of Lubbock, P.A. to furnish information to the insurance carrier concerning my illness and treatments, and I hereby assign to the physician all payments for medical services performed by this office and rendered to myself or my dependents. In the event that payment must be issued to the policy holder as stated in my contract, I authorize this payment be mailed to the provider of services. I understand that I am responsible for my copay, deductible, coinsurance and out of pocket maximums, as well as any services denied or not covered by my insurance company.

Signature ____________________ **Date** ____________
(If completing online, you may submit unsigned form and then sign upon arrival)