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

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# ____

Street / Mailing Address ____ City ____ State ____ Zip Code ____

Home Phone (with Area Code) ____ Cell Phone (with Area Code) ____ Work Phone (with Area Code) ____

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 Emergency Contact ____ Relationship ____ Phone Number (with area code) ____

Insured Last Name ____ First Name ____ Middle Name ____

Date of Birth ____ male female Marital Status ____ SS# ____

Address ____ City ____ State ____ Zip Code ____

Cell Phone (with Area Code) ____ Work Phone (with Area Code) ____

Employer ____ Employer Address ____

Relationship to Insured: Self Spouse Child Other ____

Referring Physician ____ Phone (with Area Code) ____

Family/Primary Physician ____ Phone (with Area Code) ____

Preferred Pharmacy ____ Location ____ Phone (with Area Code) ____

How did you hear about us? Physician referral TV/Online Ad Web Search Other ____

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)