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 Otolaryngology
 Head and Neck Surgery



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

PATIENT INFORMATION (CHILD)

Chart: _____

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

Last Name _____		First Name _____		Middle Name _____	Suffix _____
Date of Birth _____		SS# _____	Preferred Language (s) _____		
Street /Mailing Address _____		City _____	State _____	9 Digit Zip Code _____	
Preferred Phone (with Area Code) _____		May we contact you via email? No Yes		Email Address: _____	
Ethnicity:	Hispanic	Non-Hispanic	Declined		
Race:	Native American/Alaskan	Asian	Black	Caucasian	Pacific Islander Other Declined

Father/ Guardian Name _____			Mother/ Guardian Name _____		
Date of Birth _____	SS# _____	Insured _____	Date of Birth _____	SS# _____	Insured _____
Street Address _____			Street Address _____		
City _____	State _____	Zip _____	Responsible Party _____	City _____	State _____ Zip _____ Responsible Party _____
Home Phone (with Area Code) _____			Home Phone (with Area Code) _____		
Cell Phone (with Area Code) _____ Full Custody _____			Cell Phone (with Area Code) _____ Full Custody _____		
Work Phone (with Area Code) _____			Work Phone (with Area Code) _____		
Employer _____ Joint Custody _____			Employer _____ Joint Custody _____		
Employer's Street Address _____			Employer's Street Address _____		
City _____	State _____	Zip _____	City _____	State _____	Zip _____

Referring Physician _____		Phone _____
Family / Primary Physician _____		Phone _____
Pharmacy _____	Location _____	Phone _____
Emergency Contact Other Than Parent or Guardian _____	Relationship _____	Phone _____
How did you hear about us? Physician Referral TV/Online Ad Web Search Other _____		

Payment of Fees

If the patient is a minor, the person(s) scheduling and accompanying the patient to the appointment will be the responsible party and therefore is responsible for all payments. 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 insurance carriers 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 any amount not covered by insurance.

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