

New Est.

Tucson Ear, Nose, & Throat Associates, P.C.

Stanley W. Coulthard, M.D.
Robert B. Cravens, Jr., M.D.
Robert L. Dean, M.D.

Joe M. Huerta, M.D.
William R. LaMear, M.D.
Keith C. Soderberg, M.D.

Jon C. Richins, M.C.D., F-AAA
Stephanie M. Salcido, M.A., F-AAA
Kristen M. Schmidt, M.S., F-AAA
Abel Smith, M.S., F-AAA

Legal Last Name: _____ Legal First Name: _____ MI: _____

Address: _____

Street City State Zip
Home Phone: _____ Work Phone: _____ Marital Status: _____

Date Of Birth: ____/____/____ Age: ____ Gender: ____ SSN or Driver's License #: _____
Month Day Year

Are you actively employed? ____ Retired ____ Full time student ____ Patient's Employer: _____ Phone _____

Spouse's Name: _____ Date of Birth: ____/____/____
Month Day Year

Spouse's Employer: _____ Phone: _____

Emergency Contact: _____
Name Phone Relationship

Primary Care Physician: _____ Referring Physician: _____

PLEASE COMPLETE IF PATIENT IS A MINOR

Father's Name _____ Phone: _____ Date of Birth: _____

Mother's Name _____ Phone: _____ Date of Birth: _____

Guardian's Name _____ Phone: _____ Date of Birth: _____

INSURANCE INFORMATION

Relationship to Insured: Self ____ Spouse ____ Child ____ Other (Please Specify) _____

Primary Insurance: _____ Policy Holder Name: _____

ID/Member #: _____ Group #: _____ Copay: _____

Secondary Insurance: _____ Policy Holder Name: _____

ID/Member #: _____ Group #: _____ Copay: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS:

Tucson Ear Nose & Throat is contracted with frequently used plans, which require appropriate referrals. **Obtaining this referral is the patient's responsibility.** If seen without the necessary authorization and eligibility, you are responsible for any charges incurred, which includes hearing tests. I ____ do ____ do not (please check one) authorize the release of medical information to process my claim for insurance purposes. I do authorize that insurance benefits be paid directly to Tucson Ear Nose & Throat.

I VERIFY THAT THE ABOVE INFORMATION IS CURRENT AND CORRECT.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I acknowledge that I have been informed that the Notice of Privacy Practices for Tucson Ear Nose & Throat, P.C. is posted in the office for review.

Signature: _____ Date: _____