Northland Ear, Nose & Throat, P.C.
2521 Glenn Hendren Dr., Ste. 104
Liberty, MO 64068
(816) 781-1001 or (800) 892-8007
www.northlandent.com

*****Please arrive early to your appt.**
*****Please bring insurance card(s).**
*****Please bring a photo ID.**

Patient's Personal Information: (please print and complete ALL sections)

Last Name_____ Legal First Name_____ Middle_____
Street Address_____ Apt#_____ City_____ State_____ Zip _____
Date of Birth _____ Age _____ Sex _____ Social Security # _____
Marital Status _____ Home Phone _(_____)_____ Cell Phone (_____)_____
Employer/School Name _____ Business/School Phone (_____)_____Ext_____
Employer/School Address _____Email (Patient//Guardian)_____

Spouse Full Name _____ Spouse Date of Birth _____
Spouse Social Security # _____ Spouse Cell Phone (_____)_____
Spouse Employer _____ Spouse Work Phone __(_____)_____Ext_____

Emergency Contact (not living with you) _____
Relationship _____ Address _____ Phone __(_____)_____

Family Physician _____
Physician Phone _____

Referring Physician_____
Physician Phone _____

Responsible Party/Next of Kin Information

Father's Name _____
Address _____
Social Security # _____
Home Phone __(_____)_____Cell__(____)_____
Work Phone __(_____)_____
Employer _____
Birth date _____

Mother's Name _____
Address _____
Social Security # _____
Home Phone __(_____)_____Cell__(____)_____
Work Phone __ (_____)_____
Employer _____
Birth date _____

Medical Insurance Information (Please present your CURRENT insurance card(s), photo ID, and referral-if applicable)

Primary Insurance: Effective Date _____
Name of Ins. Co. _____
Subscriber's Name _____
Soc. Sec./Cert. # _____
Employer's Name _____
Group # _____

Secondary Insurance: Effective Date _____
Name of Ins. Co. _____
Subscriber's Name _____
Soc. Sec./Cert. # _____
Employer's Name _____
Group # _____

Authorization/Assignment/Release of Information
I, hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private, HMO/PPO and commercial insurance's as well as third party payers be made on my behalf to Northland ENT, P.C. for any services furnished to me or my family by Northland ENT, P.C. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment or for determination of benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Signature of Patient or Legal Guardian/Parent Date (Rev 03/07)

I hereby acknowledge that I have been presented with a copy of the Northland ENT, P.C.'s Notice of Privacy Practice, have read and had an opportunity to discuss it with a staff member. **Initial_____**