Santa Barbara ENT
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2420 Castillo Street, Suite 100
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(PLEASE PRINT)

PATIENT INFORMATION

Name _____ Social Security#_____-_____-_____
Last First Middle

Address _____
Street or PO Box City State Zip

Email _____ Home Phone: (_____)_____

Sex *M* *F* Date of Birth _____ Marital Status _____ Cell Phone: (_____)_____

Who is your primary doctor? _____

Emergency contact _____Relationship _____ Phone Number: (_____)_____

May we share your medical information with your emergency contact? YES NO

PRIMARY INSURANCE

Please provide valid picture ID and Insurance card(s) to front desk to be copied.

Insurance company _____ Member# _____ Group#_____

Person responsible for account if not the patient _____ Birth Date _____

Relationship to Patient _____ Social Security# _____-_____-_____

Address (if different from patient's) _____

Person responsible is employed by_____

ADDITIONAL INSURANCE

Insurance company _____ Member# _____ Group#_____

Person responsible for account if not the patient _____ Birth Date _____

Relationship to Patient _____ Social Security# _____-_____-_____

Address (if different from patient's) _____

Person responsible is employed by_____

FINANCIAL AGREEMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to Santa Barbara ENT, realizing that I am responsible for all co-pays, deductibles, co-insurance and any non-covered service balances. I understand that I am financially responsible for charges whether or not they are covered by insurance. I am responsible for contacting my insurance provider directly to confirm benefits and coverage. I authorize the doctor's office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____