

**ENT Specialists/Jerry W. Sonkens,MD/Randal W. Swenson,MI  
David K .Palmer,MD/John E. Butler/Justin D. Gull,MD**

**Personal Information**

Today's Date: \_\_\_\_\_ Account #: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Sex: \_\_\_\_\_ May we leave information on your answering machine or voicemail?  
Primary Phone: (number you wish to be reached at) \_\_\_\_\_ Cell #: \_\_\_\_\_  
Work No: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Full Time Student: Yes No

**In the event of an emergency please contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_  
Minor Patients: Name of Parent/Guardian \_\_\_\_\_  
Who Referred you? Physician Family Friend Phone Book Insurance Co. Other  
Referring Physician's Name: \_\_\_\_\_ Phone No: \_\_\_\_\_  
Address: \_\_\_\_\_

**Insurance Information:**

**Please present your insurance card(s) to the receptionist. Please give complete information.**

Primary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
Patient's Relationship to Insured: Self Spouse Child Other  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
Patient's Relationship to Insured: Self Spouse Child Other  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

**NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:**

If we are filing insurance for your visit, we must have complete information and any required referral at the time of t provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. You due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary do reimbursement upon your request. **Failure to make your co-pay at time of service will result in \$10 billing charge.**

OFFICE POLICY ON PAYMENT: We accept cash, heck and major credit cards. Returned checks are assessed a \$20 fee over 60 days will have a minimum \$5 service charge or will be charged an interest rate of 1.5% per month (18% per an balance is not paid as agreed, the undersigned agrees to pay a collection fee equal to 40% of the unpaid balance. In th collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney's fees.

**A 24 hour cancellation notice is need to avoid a \$25 "NO SHOW" charge.**

**I have read the above information and understand that I am responsible for payment for services I receive.**

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

