SOUTHERN E.N.T. ASSOCIATES, INC.

(A Medical Corporation)

Last Name:	**First Name:**	**Middle Initial:**
Maiden Name:	**Preferred Name:**	**Soc. Security #:**
Date of Birth:	**Driver's License #:**	**Sex:** **Male** **Female**
Marital Status:	**Preferred Provider:**	**Home #:**
Address:		**Work #:**
City, State, Zip:		**Cell #:**

Do you have an email address: ☐**Yes** ☐**No**

Email:

* By providing your email address you will have access to our patient portal. Through the patient portal you will have access to your health history, you can ask us questions, request refills, or request appointments.

Race (circle one):

American Indian/Alaska Native	Nat Hawaiian/Pacific Islander
African American/Black	Other Race
Asian	Declined
White	Unknown

Ethnicity (circle one):

Hispanic/Latino

Not Hispanic/Latino

Declined

Unknown

Primary Language Used (circle one):

Arabic	French	Italian	Portugese
Chinese	German	Japanese	Russian
English	Greek	Korean	Spanish
Filipino	Hindi	Polish	Vietnamese

Preferred Pharmacy:	**Referring Physician:**
Address:	**Primary Physician:**
City, State, Zip:	

Employer:	**Emergency Contact:**	**Phone #:**

Primary Ins:	**Policy ID #:**
Policy Holder:	**Group #:**
Policy Holder Relationship:	**Policy Holder D.O.B.:**
Policy Holder S.S. #:	

Secondary Ins:	**Policy ID #:**
Policy Holder:	**Group #:**
Policy Holder Relationship:	**Policy Holder D.O.B.:**
Policy Holder S.S. #:	

Responsible Party:	**Soc. Security #:**
Address:	**Date of Birth:**
City, State, Zip:	

Insurance Authorization and Assignment

I authorize release of any medical information necessary to process any insurance claims, and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I further assign to the physician or supplier of service for myself and/or dependents any and all rights to penalties and/or attorney's fees under Louisiana law, including La. R.S. 22:657, resulting from my insurance carrier's or managed care plan's failure to timely pay any claims for medical benefits. I understand I am responsible for any deductibles, co-insurance/or amounts for services not covered by the insurance carrier. If I am a participant in a managed care plan, I also authorize the audit of my chart by that plan.

Signature Date