

**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 (____) _____	
<b>Family Physician</b> _____			<b>Referring Physician</b> _____		
<b>Physician Phone</b> _____			<b>Physician Phone</b> _____		

**Responsible Party/Next of Kin Information**

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

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

<b>Primary Insurance: Effective Date</b> _____		<b>Secondary Insurance: Effective Date</b> _____	
Name of Ins. Co. _____		Name of Ins. Co. _____	
Subscriber's Name _____		Subscriber's Name _____	
Soc. Sec./Cert. # _____		Soc. Sec./Cert. # _____	
Employer's Name _____		Employer's Name _____	
Group # _____		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** \_\_\_\_\_