# Alpine ENT Face Sheet

**Today's Date: _____ Chart #: _____**

**Personal Information**

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Date of Birth: _____ Sex: _____ Marital Status: Married / Single / Divorced / Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email:_____

Please circle the option you would like us to use to send appointment reminders: Home phone / Call to cell phone / Text to cell phone / Email

Referring Provider's Name & Contact info: _____

Primary Care Physician's Name & Contact info: _____

**Insurance Information:**

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

**Primary Insurance: _____**

Patient's Relationship to Subscriber: Self / Spouse / Child / Other

Subscriber Name: _____ Subscriber DOB: _____

Member ID #: _____ Group #: _____

**Secondary Insurance: _____**

Subscriber Name: _____ Subscriber DOB: _____

Patient's Relationship to Subscriber: Self / Spouse / Child / Other

Member ID #: _____ Group #: _____

**If we are seeing you for a Work Related Injury or Auto Accident related injury please list the insurance we should bill, the date of injury, claim number, adjuster name and contact number below:**

**Name of Work Comp or Auto Carrier: _____**

**Injury is: Work Related / Auto Related Date of Injury:_____ Claim Number: _____**

**Adjuster Name:_____ Contact Phone Number: _____**

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot 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 will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed may be considered surgery by 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 documentation to file for reimbursement upon your request.

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

**Patient/Responsible Party Signature:_____ Date: _____**

Responsible Party Name: _____ Responsible Party Date of Birth: _____