

Yankton Ear, Nose & Throat, P.C.



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PATIENT INFORMATION

Name (First, Middle, Last)

Responsible Party or Parents name (If patient is a minor)

Address

Patient's employer or parent occupation

City State Zip

Work Phone

Date of Birth Age Sex M F

Spouse's Name

Home Phone Marital Status S M D W

Employer (Spouse's)

Social Security Number

Work Phone (Spouse's)

In case of Emergency – Whom should we contact?

Has any member of your immediate family been a patient at Yankton Ear, Nose & Throat, P.C.? Yes No

Name

Name

Relationship

Referring Doctor/Source

Address

Information concerning your care provided by Yankton Ear, Nose & Throat, P.C. will be forwarded to your referring doctors/source unless otherwise specified here.

City State Zip

Telephone – Day Telephone – Evening

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Carrier

Secondary Insurance Carrier

Insurance Company Name

Insurance Company Name

Address

Address

City State Zip

City State Zip

Phone Policy Number

Phone Policy Number

Group Number/Name Insured Name & Birth Date

Group Number/Name Insured Name & Birth Date

Patient's Relationship to Insured?

Self Spouse Dependent Other

Patient's Relationship to Insured?

Self Spouse Dependent Other

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Yankton Ear, Nose & Throat, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. **WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.**

Signed

Date