

Medical Center Ear, Nose and Throat Associates

Drs. Herndon, Horwitz, Katz, Kaplan, Ahuja

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Last Name <i>Apellido</i>		First name <i>Primer Nombre</i>		MI <i>Segundo Nombre</i>	
Street Address <i>Dirección</i>		City <i>Ciudad</i>		State <i>Estado</i>	ZIP code <i>Zona Postal</i>
Date of Birth <i>Fecha de nacimiento</i>		Sex: M F <i>Sexo: Hombre Mujer</i>		Social Sec. No. <i>No. de Seguridad Social</i>	
Home phone no <i>Numero telefonico</i>		Work phone no. <i>Numero de su trabajo</i>		Email <i>Correo Electronico</i>	
Occupation <i>Oficio</i>		Employer <i>Lugar donde Trabaja</i>		Cell Phone Number	
Emergency Contact name <i>Persona a llamarse en caso de emergencia</i>			Emergency contact number <i>Numero para llamar en caso de emergencia</i>		
Spouse's information					
Marital Status S M D W <i>Estado Marital S C D V</i>		Spouse's name <i>Nombre de su esposo/a</i>		Spouse's SSN. <i>SSN de su esposo/a</i>	
Spouse's employer <i>Lugar donde su esposo/a trabaja</i>		Spouse's Work No. <i>Numero de su trabajo</i>			
Guarantor Information					
Guarantor Name <i>Nombre de Guardador</i>		Address <i>Dirección</i>		City, State, Zip code <i>Ciudad, Estado, Zona Postal</i>	
Social Security No. <i>No. de Seguridad Social</i>		Date of Birth <i>Fecha de nacimiento</i>		Home Phone no. <i>Numero telefonico</i>	
Employer <i>Lugar donde trabaja</i>		Occupation <i>Oficio</i>		Work Phone no. <i>No. de su trabajo</i>	
Insurance Information					
Insurance company name <i>Nombre de seguro</i>			Insurance Address <i>Dirección de seguro</i>		
Insurance Phone No. <i>Numero telefonico de su seguro</i>			Name of Insured Employee <i>Nombre del asegurado</i>		
Social Security No. <i>SSN del asegurado</i>					
Date of Birth <i>Fecha de nacimiento</i>			Work Phone No. <i>Numero de su trabajo</i>		
Group No. <i>No. del grupo</i>			Policy No. <i>No. de la poliza</i>		
ID # <i>No. de certificado o de identification</i>					
Is the patient covered by Medicare: Yes No <i>¿Tiene usted Medicare? Sí No</i>			Medicare number <i>No. de Medicare</i>		
Do you have a secondary insurance? Yes No <i>¿Tiene Usted seguro secundario? Sí No</i>			Name of policy holder <i>Nombre del asegurado</i>		
Secondary Insurance name <i>Nombre de seguro secundario</i>			Policy No. <i>No. de Poliza</i>		
Group No. <i>No. de Grupo</i>			ID No. <i>No. de certificado o de identificación</i>		
Which doctor do you wish to see? <i>¿Cual doctor quiere ver?</i>					
Reason for this visit <i>La razón por esta consulta</i>					
What doctor referred you to this office? <i>¿Cual médico lo/a mandó a esta clínica?</i>					
Should we send the referring doctor a report of your condition? YES NO <i>¿Podemos enviar un reporte a su médico? Sí No</i>			What is your referring doctor's phone number? <i>Numero telefonico de su médico</i>		
What is your referring doctor's address? <i>¿Dirección de su médico?</i>					
Your pharmacy <i>Nombre de su farmacia</i>			Pharmacy address <i>Dirección de la farmacia</i>		
Pharmacy Number <i>Numero telefonico de su farmacia</i>					

We request that payment for services be made at the time the service is rendered. Payment may be made by debit card, check, cash or major credit card. If your treatment here is due to a job-related injury, we must have written authorization from the employer or the insurance carrier before an account can be established.

We ask that you read and acknowledge the following statements with a signature:

1. I authorize the physicians of Medical Center Ear, Nose and Throat Associates of Houston to administer reasonable and proper medical care by today's standards.
2. I hereby acknowledge that I am responsible for payment of my own, and/or my dependent's charges.
3. Some of the physicians at Medical Center Ear, Nose, and Throat Associates are on staff and / or have an economic interest in the following facilities: Rest Technologies, Med Center Ambulatory Surgery, and University General Hospital

Signed: _____

Date: _____