RED RIVER E.N.T. & ASSOC.

Patient Information Form

OFFICE USE ONLY

¨ **Paul A. Guillory, M.D.**

¨ **Renick P. Webb, M.D.**

¨ **Christian J. Wold, M.D.**

Date _____

Name _____ Age _____ Date of Birth _____ Race _____
Last First Middle

Marital Status: ☐ single ☐ married ☐ other _____ Employed: ☐ Yes | ☐ No Student: ☐ full-time ☐ part-time

Sex: ☐ male ☐ female Social Security # _____ Drivers License # /State _____

Mailing Address _____ APT# _____ Email _____

City / State / Zip _____

Phone: Home # _____ Work # _____ other # _____ Employer _____

Position _____ Employer's Address _____
PO Box/Street City/State/ZIP

Whom May we Contact in case of Emergency? _____ Phone # _____ Relationship _____

RESPONSIBLE PERSON INFORMATION: ☐ Spouse | ☐ Mother | ☐ Father | ☐ Guardian

Name _____ Social Security # _____ DOB _____ Employer _____

Address _____ Phone: work # _____ other # _____

PATIENT INSURANCE INFORMATION

Insured Party _____ Employer _____ Social Security# _____
(Name on Insurance Card)

Claim Group: _____DOB:_____ Relationship_____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

Paul A. Guillory, M.D. | Renick P. Webb, M.D. | Christian J. Wold, M.D.

Or if my current policy prohibits direct payment to my doctor and/or the service provider, I hereby also instruct and direct you to make the check to me and mail it as follows:

Paul A. Guillory, M.D. | Renick P. Webb, M.D. | Christian J. Wold, M.D.

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee(s), and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize that my doctor and/or the service provider may release a copy of my sleep reports to the physicians I have listed on this form. I authorize my doctor and/or the service provider to initiate a compliant to the Insurance Commissioner for any reason on my behalf.

I understand and agree (that regardless of my insurance), I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all the information on this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

X_____ _____

Signature of Patient or Legal Representative Date