Welcome To Our Office

Allergy Ear Nose & Throat INSTITUTE
EXCELLENCE SINCE 1992
"To God be the Glory"

Dale B. Smith, D.O.
Lonnie C. Scholl, PA-C
Westley A. Carter, PA-C

Main Office: 4920 S.W. Lee Blvd. • Lawton, OK 73505 • 580.536.8844
Satellite Office: 1015 E. Broadway Suite 103 • Altus, OK 73521 • 580.477.1033

How did you hear about us? ❑Family/Friend ❑Website ❑Physician Referral ❑Phonebook ❑Facebook ❑Billboard ❑Newspaper ❑TV Commercial ❑Magazine ❑Other_____

Referring Physician:_____ Family Physician:_____

PATIENT DEMOGRAPHIC INFORMATION

Last Name:_____First Name:_____Middle Initial:_____

DOB:_____Age:_____ Sex: ❑ Male ❑ Female SSN:_____-_____-_____

Mailing Address:_____City:_____State:_____ZIP:_____

Home Phone:_____Cell Phone:_____Email:_____
(Confidential)

Employer:_____City:_____Work Phone:_____

Emergency Contact:_____Relationship:_____Phone:_____or_____
(Name)

Your preferred method of contact:❑ Cell Phone ❑Home Phone ❑Work Phone ❑Email ❑Text Message

PARENT / GUARDIAN OF MINOR / FINANCIAL RESPONSIBLE PARTY DEMOGRAPHIC INFORMATION

*The financial responsible party is the parent / guardian who will be signing below and accepting financial responsibility.

Last Name:_____First Name:_____Middle Initial:_____

DOB:_____Age:_____ Sex: ❑ Male ❑ Female SSN:_____-_____-_____

Mailing Address:_____City:_____State:_____ZIP:_____

Home Phone:_____Cell Phone:_____Email:_____
(Confidential)

Employer:_____City:_____Work Phone:_____

POLICY HOLDER INSURANCE COVERAGE INFORMATION

Primary Insurance:_____Policy Number:_____Grp. Number:_____

Policy Holder:_____DOB:_____SSN:_____Effective Date:_____

Home Phone:_____Address:_____City:_____State:____ZIP:_____

Employer:_____City:_____Work Phone:_____

Secondary Insurance:_____Policy Number:_____Grp. Number:_____

Policy Holder:_____DOB:_____SSN:_____Effective Date:_____

Home Phone:_____Address:_____City:_____State:____ZIP:_____

Employer:_____City:_____Work Phone:_____

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FINANCIAL AGREEMENT

I authorize the release of any medical information necessary to process this claim, and I authorize payment of medical benefits to the Allergy Ear Nose and Throat Institute (AENTI). AENTI is happy to assist in filing my primary insurance, but they do not render service on the assumption that my charges will be paid in full by my insurance company. If I do not provide all insurance(s) and correct insurance information at time of visit, there will be a fee for refiling. All services rendered are charged to the patient responsible for payment, regardless of insurance coverage. There will be a charge as allowed by law, for all returned checks. **Failure to cancel my appointment with at least a 24 hour notice will result in a $75.00 charge.** By signing below I acknowledge that I will be the financially responsible party billed for payment of services. I authorize any collection agency working on AENTI's behalf to contact me via current and any future cellular phone number(s) or wireless device(s) regarding my delinquent account(s) I owe to AENTI. I authorize AENTI and its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls, in their effort to contact me for purposes of collecting any portion of my account which is past due. If collection actions become necessary, I will be responsible for the balance and all collection fees. I have read this disclosure and agree to the terms described above.

Signed by Patient if 18 or over:_____ Date:_____

*Signed by Financial Responsible Party:_____ Date:_____
(If different than patient)