Welcome To Our Office

4920 S.W. Lee Blvd. • Lawton, OK 73505 • 580-536-8844

Dale B. Smith, D.O.
George Katsantonis, M.D., F.A.C.S.
Lonnie C. Scholl, PA-C

How did you hear about our practice? _____

Referring Physician: _____ Family Physician: _____
First Name Last Name First Name Last Name

PATIENT DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ Age _____ Sex: ☐Male ☐Female SSN: _____

Mailing Address: _____ ZIP: _____ City: _____ State: _____

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

Employer: _____ City: _____ Email: _____
(Confidential)

Emergency Contact: _____ Relationship: _____ Phone: _____ or _____
(Name)

Your preferred method to contact you: ☐Cell Phone ☐Home Phone ☐Work Phone ☐E-mail ☐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: _____ ZIP: _____ City: _____ State: _____

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

Employer: _____ City: _____ Email: _____
(Confidential)

POLICY HOLDER INSURANCE COVERAGE INFORMATION

Primary Insurance: _____ Policy Number: _____ Group Number: _____

Policy Holder: _____ DOB: _____ SSN: _____ Effective Date: _____

Hm Phone: _____ Address: _____ ZIP: _____ City: _____ State: _____

Secondary Insurance: _____ Policy Number: _____ Group Number: _____

Policy Holder: _____ DOB: _____ SSN: _____ Effective Date: _____

Hm Phone: _____ Address: _____ ZIP: _____ City: _____ State: _____

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. We will be happy to assist in filing your primary insurance, but we do not render service on the assumption that your charges will be paid in full by your insurance company. If you 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 your appointment with at least 24 hours notice will result in a $75.00 charge.** The person signing below will be the financial responsible party billed for payment of services. If collection actions become necessary, you will be responsible for the balance and all collection fees.

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

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