



## SOUTHWESTERN COLORADO EAR, NOSE & THROAT ASSOCIATES

Mercy Medical Plaza • One Mercado Street, Suite 205 • Durango, CO 81301

phone 970-385-7272 • fax 970-385-7299 • [www.swcoent.com](http://www.swcoent.com)

### ✦ 1. Patient Registration / Demographics

#### Patient Information

- Full Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Birth Gender  Male  Female
- Identified Gender  Male  Female  Other
- Social Security: \_\_\_\_\_
- Phone Number: \_\_\_\_\_ Secondary Number: \_\_\_\_\_
- Email Address: \_\_\_\_\_
- Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### Emergency Contact

- Name: \_\_\_\_\_
- Relationship: \_\_\_\_\_
- Phone: \_\_\_\_\_

#### Insurance Information

- Primary Insurance: \_\_\_\_\_
- Subscriber Name: \_\_\_\_\_
- Subscriber DOB: \_\_\_\_\_
- ID #: \_\_\_\_\_ Group #: \_\_\_\_\_
- Secondary Insurance: \_\_\_\_\_
- Subscriber Name: \_\_\_\_\_
- ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

#### Responsible Party (if different)

- Name: \_\_\_\_\_
- Relationship: \_\_\_\_\_
- Phone: \_\_\_\_\_



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Patient Name: \_\_\_\_\_ Dat of Birth: \_\_\_\_\_

**✦ 2. Health History & Physical Information**

Primary Concern / Reason for Visit:

\_\_\_\_\_

**Medical History (check all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies -Environmental | <input type="checkbox"/> Hearing Loss            |
| <input type="checkbox"/> Allergies -Food          | <input type="checkbox"/> Sleep Apnea             |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Acid Reflux              | <input type="checkbox"/> Tinnitus                |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Chronic Sinusitis        | <input type="checkbox"/> Other: _____            |

**Surgical History :**

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Known Allergies (medications/environmental):**

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

- Tobacco Use:  Yes  No  Former
- Alcohol Use:  Yes  No
- Recreational Drug Use:  Yes  No
- Occupation: \_\_\_\_\_

**Family History (relevant conditions):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Pharmacy: \_\_\_\_\_



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### **✦ 3. Consent to Treat**

I consent to evaluation, diagnosis, and treatment by the providers of **Southwestern Colorado Ear, Nose and Throat**. This may include routine medical care, diagnostic testing, and minor procedures as deemed necessary.

I understand that:

- I have the right to ask questions regarding my care
- I may refuse treatment at any time
- No guarantees have been made regarding outcomes

For minors: I certify I am the legal guardian authorized to consent.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### **✦ 4. Financial Responsibility Agreement**

I understand that I am financially responsible for all services provided by Southwestern Colorado Ear, Nose and Throat, **including charges not covered by insurance.**

I agree to:

- Provide accurate up to date insurance information
- Pay all co-pays, deductibles, and balances when due
- **Understand that insurance authorization is not a guarantee of payment**
- **Pay for services deemed non-covered**

If my account is sent to collections, I agree to pay reasonable collection costs and fees as permitted by Colorado law.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### **✦ 5. Cancellation / No-Show Policy**

At **Southwestern Colorado Ear, Nose and Throat**, we strive to provide timely care to all patients.

- We require **at least 24 hours' notice** for cancellations or rescheduling
- Missed appointments or late cancellations may result in a **no-show fee** (\$25.00 clinic/\$75.00 Surgical)
- Repeated missed appointments may result in dismissal from the practice

By signing below, I acknowledge and agree to this policy.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### **✦ 6. Authorization to Release Information**

I authorize **Southwestern Colorado Ear, Nose and Throat** to:

Release my medical information to:

Name/Facility: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

Obtain medical records from:

Name/Facility: \_\_\_\_\_

This authorization includes information necessary for treatment, payment, and healthcare operations, including ENT-related conditions.

I understand:

- I may revoke this authorization at any time in writing
- This authorization expires in one year unless otherwise specified

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### **✦ 7. HIPAA Acknowledgment of Privacy Practices**

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices for Southwestern Colorado Ear, Nose and Throat.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_