Ronald J. Darling, M.D.
Thomas P. Belson, M.D.
William A. Darling, M.D.
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Mary C. Fox, M.D.

MORELAND
Ear, Nose & Throat Group

Suite 102
1111 Delafield Street
Waukesha, WI 53188
(262)-547-1614
FAX (262) 547-0192

PATIENT

Patient Information (Please Print)

Miss / Mrs. / Mr. | Patient Last Name | First Name | Middle Name | Date of Birth | Age

Address, Street No. Apt., | City | State | Zip | Social Security No.

Sex: ☐ Male ☐ Female | Marital Status: ☐ M ☐ S ☐ D ☐ W | Home Phone | Day Time Contact Number

Spouse Name | Student Status: Full Time ☐ Part Time ☐

INSURANCE

Primary Insurance Information:

Insured's Name | Relationship | Social Security # | Date of Birth

Employer | City, State, Zip

Insurance Company

Insurance Company Address | City, State, Zip | Phone

ID# | Group #

Secondary Insurance Information:

Insured's Name | Relationship | Social Security # | Date of Birth

Employer | City, State, Zip

Insurance Company

Insurance Company Address | City, State, Zip | Phone

ID# | Group #

RESPONSIBLE PARTY

Responsible Party — Please complete this section if someone other than this patient is responsible for payment.

Miss / Mrs / Mr. | Name | Relationship | Home Phone

Street - Address - Apt. | City | State | Zip

Employer | City, State, Zip | Business Phone

DOCTOR

PRIMARY CARE PHYSICIAN:

Doctor's Name | Street Address | City | State | Zip

Did he/she refer you to us? Yes ☐ No ☐ If not, how did you hear of us? ____________

AUTHORIZATION AND ASSIGNMENT

Insurance Authorization and Assignment (Please read and sign)

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

I hereby authorize Moreland ENT to furnish information regarding my treatment and illness to insurance carriers. I hereby assign to Moreland ENT any payments for medical services rendered to me or my dependents.

I understand that I am responsible for payment of all fees for medical services regardless of insurance coverage or payment by the insurance company of usual and customary fees with the exception of medical assistance or other fully sponsored government accounts. I understand that usual and customary fees may not be accepted as full payment for medical services by Moreland ENT.

Signature of Patient or Responsible Party ____________ Date of Signature ____________

Thank You For Your Cooperation in Furnishing the Above Information

MORELAND EAR, NOSE AND THROAT GROUP, LTD.