EAR, NOSE & THROAT ASSOCIATES
WILSON T. BARHAM, M.D.
LEE A. MILLER, M.D.

Social Security # ____________ Patient: __________________________ / ______ / ________________________
First Name MI Last Name

Address: ______________________________________ Zip: _________ City: _______________ State: ________

Date of Birth: _______________ Marital Status: Married Divorced Widowed Single Gender: Male Female

Home Phone: _____________________ Work Phone: _____________________ Cell Phone: _______________

Referring Physician: ___________________________ Primary Care Physician: _________________________

Pharmacy Name: _______________________________ Phone: ___________________

Employee Status: Full Time Part Time Retired Self Emp. Not Emp. Employer: _________________
Student Status: Full Time Part Time Not Student

Guarantor Information

Responsible Party: ____ Phone: ___________________

Address: ______________________________________ Zip: _________ City: _______________ State: ________

Employer: ____ Phone: ___________________

Date of Birth: __________ SS# _______________ Relationship to Patient _______________________________

Primary Insurance: ____

Insurance ID: ____________________________ Group: _____________ Employer: ______________________

Insured's Name: ________________________________ Date of Birth: ________ SS# ______________________

Relationship to Insured: Child Spouse Self

Secondary Insurance: ____

Insurance ID: ____________________________ Group: _______ Employer: _____________________________

Insured's Name: ________________________________ Date of Birth: ________ SS# ______________________

Relationship to Insured: Child Spouse Self

Person to contact in case of Emergency (Not in your Home): ______________________________

Relationship to Patient: _________________________________ Phone: _____________

Payment Policy

Payment in full for office charges is expected at the time service is rendered. If our office is contracted with your insurance company then you are responsible for the copay or coinsurance amount at the time of service. I certify that the above information is correct to the best of my knowledge.

Signature: ____ Date: ______________
Patient or Legal Guardian

Otolaryngology/Head and Neck Surgery
2802 Kilpatrick Boulevard Monroe, La 71201
Office 318-855-6282 Fax 318-855-6424