WELCOME TO OUR OFFICE

Hearing & Balance Disorders   Facial Nerve Disorders   Skull Base Surgery   Allergy

Plano Office: 6509 W. Plano Pkwy, Plano, TX 75093 972-781-1462 (Fax) 972-378-4125
Fort Worth Office: 900 Jerome St., Suite 200, Fort Worth, TX 76110 817-332-3277 (Fax) 817-332-3299

DEAR ______________________________ **DATE**_________________

Thank you for calling our office. Your appointment details are as follows:

Date:________________ **Time:**______________ **Office** Ft. Worth ⬭ Plano ⬭

With: ⬭ Dr. Robert Owens ⬭ Lori McGee, FNP

Enclosed you will find forms to be completed. Please return them to our office before your visit or bring them with you 15 minutes before your scheduled appointment time.

1. Patient Information
2. Office Policy
3. Patient Health History

Please bring the following items with you to your appointment:
1. Insurance card(s) & Driver's License
2. Copies of all your hearing tests. We are required by law to keep all copies you bring. Please make duplicate copies for yourself before your visit.
3. X-Ray Images. Please bring the actual CT Scan and MRI Images (films) with you so we can personally review them at the time of your visit.
4. Referral Form. (If your insurance policy requires this) If you insurance requires that you obtain a referral, we **MUST** have this **PRIOR** to your appointment. If you come without your referral , according to the strict 'no exceptions' term of your insurance policy, your appointment may have to be rescheduled because your insurance will not reimburse us for a visit without a valid referral.
5. Your completed enclosed forms (if you have not mailed them to us previously). If you forget your forms, you will need to fill out a new set in our office and this may delay your appointment.

Please call if you have any questions concerning your appointment.

If you fail to keep this appointment there is a charge of $75 dollars. If you need to cancel or reschedule your appointment we require you call 24 hours in advance.

Thank you for your cooperation and we look forward to seeing you!

PATIENT INFORMATION – Please Print Clearly

Last Name:____________________________ First Name: ________________________ MI _________

Home Address: ____

City: _______________________________________ State: _________ Zip Code: _____________

Phone: Home_________________ Work ___________________Ext______Cell_________________
Email:____
□ Male □ Female □ Single □ Married □ Widowed □ Divorced
Date of Birth: ______________________ Social Security Number______________________________

Occupation: _________________________ Are you retired? □ Yes □ No
Employer's Name:____
Employer's Address: ____

Referring Physician: ____
Reason for seeing Doctor:____

Person to notify in case of an emergency: ____
Phone: Home__________________ Work _________________Ext_______ Cell____________________
Relationship to patient: □ Spouse □ Mother □ Father □ Other_________________

INSURANCE – PLEASE PROVIDE INFORMATION FOR BOTH INSURANCES

Primary Insurance	**Secondary Insurance**
Company:___________________________________	Company:___________________________________
Address:____________________________________	Adress:____________________________________
City:_____________________State:_____Zip:________	City:_____________________State:_____Zip:_________
Policyholder ID No.:____________________________	Policyholder ID No.:____________________________
Group ID No.:_________________________________	Group ID No.:_________________________________
Name of Policyholder:__________________________	Name of Policyholder:__________________________
SSN:_______________________________________	SSN:_______________________________________
Date Of Birth:_________________________________	Date Of Birth:_________________________________
Policyholder Employer: _________________________	Policyholder Employer: _________________________
Relationship to Patient:_________________________	Relationship to Patient:__________________________

I consent to be examined by the Physicians of Owens Ear Center at each office visit. I agree to allow them to release to my insurance carrier or its representatives any information necessary to determine my benefits entitlement. I also assign payment of benefits to Owens Ear Center in the case payment is not made at the time of service or in the case of Medicare. I understand that payment is required at the time of service unless otherwise agreed to previously with our billing department. I understand that I am financially responsible for all charges incurred regardless of any problems which may arise with my insurance company.

Patient's Signature____________________________________ **Date:** ___________________________________