

PATIENT INFORMATION

TODAY'S DATE _____

Name _____

Address _____ **City** _____ **ST** _____ **ZIP** _____

Home Phone (____) _____ **Cell Phone** (____) _____ **Work Phone** (____) _____

SS# _____ - _____ - _____ **Date of Birth** ____/____/____ **Age** _____ **Sex** M F

PATIENT'S RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

NAME _____

ADDRESS _____ **CITY** _____ **ST** _____ **ZIP** _____

Home Phone (____) _____ **Cell Phone** (____) _____ **Work Phone** (____) _____

SS# _____ - _____ - _____ **Date of Birth** ____/____/____ **Age** _____ **Sex** M F

INSURANCE INFORMATION *PLEASE PRESENT CARD AT TIME OF CHECK IN*

Primary Insurance Name _____ **Secondary Insurance Name** _____

Name of Insured _____ **Name of Insured** _____

Insured's ID # _____ **Insured's ID #** _____

Group # _____ **Group #** _____

Relationship of patient to insured _____ **Relationship of patient to insured** _____

PHARMACY OF CHOICE: _____

CITY: _____ **PHONE:** (____) _____ **FAX:** (____) _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:**(____) _____

MEDICARE PATIENTS: I request that payment for authorized Medicare benefits be made either to me or on my behalf to Laurel ENT & Allergy, PC for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Name: _____ **Date:** _____

I authorize the release of medical information to my PCP or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications & prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party _____ **Date:** _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding or payment policies, our staff is trained to consistently inform you of the financial payment policies of the office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Applicable copayments and deductibles will be collected. We accept payment in form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate Insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and copayments. If payment is not made to our office in full within 30 days you may incur a late fee. If further collection is required you could incur collection fees, attorney fees, and all court costs to collect upon any debt you have owing our office.

Patient or Responsible Party: _____ **Date:** _____

Patient History Form

Complete **BEFORE** First Visit

Patient Name _____

Date ___/___/___

The Following is a list of diseases. If you have ever had any of these, please check the blank.

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Goiter | <input type="checkbox"/> Tonsilitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Cancer, What type?
_____ | <input type="checkbox"/> Heart Ailments | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Heartburn/Gastric Reflux | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Hay Fever, Seasonal Allergies | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Lung Disorders | <input type="checkbox"/> Sore Throat(Frequent) | <input type="checkbox"/> Cough(Frequent) |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Sleep Apnea | |

How did you hear about us?

- Internet Advertisement Friend/Family
- PCP Referral (Dr.'s Name) _____
- Specialist/Doctor other than PCP (Dr.'s Name) _____

What is the main reason for your visit today? Please describe in detail _____

List any previous surgeries you've had; include all previous ENT procedures _____

What medications are you allergic to, what type of reaction to the medication do you have? _____

List all medications you are presently taking, including nasal sprays _____

Are you or have you ever been on allergy immunotherapy? YES/NO/WAS. If yes, how long have you been on shots and how often do you get them? _____

If you were, when and why did you stop? _____

Do you or have you ever smoked? YES NO If so, how much & how long _____

FORMER smoker, roughly when did you quit? _____

Do you drink caffeinate beverages? YES NO If so, how much? _____

Please list any **BLOOD RELATIONS** who have had the below diseases.

- | | |
|--------------------------|----------------------|
| Cancer, what type? _____ | Sinus Problems _____ |
| Thyroid Disease _____ | Heart Disease _____ |
| Allergies _____ | Asthma _____ |

Laurel ENT and Allergy, PC

AUTHORIZATION TO RELEASE INFORMATION

This office adheres to strict policies with regard to release of confidential information. If you authorize Laurel ENT and Allergy, PC staff to release information regarding your care to family members, please list their full names, phone number and relationship to you.

NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

EMERGENCY CONTACT

Please give the name and number of a relative or friend whom we may contact in the event of a medical emergency.

NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

TELEPHONE MESSAGES

We may need to contact patients regarding appointments, scheduling tests, test results, etc. It may be necessary for us to contact you. It is our policy to leave detailed messages at your home if you are not available or we may need to contact you at work if an emergency arises.

May we contact and/or leave a message at home? YES NO

May we contact and/or leave a message at home? YES NO

PATIENT SIGNATURE

DATE

Laurel ENT and Allergy, PC

Statement of Patient Financial Responsibility

Laurel ENT and Allergy, PC appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment of our fees in full. As a courtesy, we will verify coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for your payment of any deductible and copayment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period you will be responsible for your balance in full.

By signing below, I state that I have read and agree to the above policy regarding my financial responsibility to Laurel ENT and Allergy, PC, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Laurel ENT and Allergy, PC, the full and entire amount of bill incurred by me or the above named patient; if applicable any amount due after payment has been made by my insurance carrier is my responsibility.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Laurel ENT and Allergy, PC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Laurel ENT and Allergy, PC, to release to appropriate agencies, any information acquired in the course of my or the above named patient’s examination and treatment.

Patient/Guarantor Signature _____ Date _____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment.

I understand that if I no show for 3 consecutive appointments, or cancel for a total of 3 appointments, I may be discharged from care.

The practice will notify you in writing, via certified mail if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Failure to Pay

If you fail to remit payment after 90 days you will automatically be sent to collections, any additional fees may be applied and will be your responsibility. It is your responsibility to remit in full, and in the entire amount owed to the collection agency.

Patient/Guarantor Signature _____ Date _____