PATIENT INFORMATION FORM

FREDERICK ENT GROUP

82 Thomas Johnson Court
Frederick MD 21702
301-698-2440

Date_____
Family Doctor_____
Referred by_____
Pharmacy/Location_____

PLEASE COMPLETE THE ENTIRE FORM

PATIENT'S NAME_____ BIRTH DATE_____
Last First MI Nickname

MARITAL STATUS_____ HEIGHT_____ WEIGHT_____

ADDRESS_____
Street P.O. Box City State Zip Code

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

EMPLOYER_____ ADDRESS_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

ADDRESS (if different from patient)_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

REASON FOR VISIT_____ DATE OF ONSET_____

DATE OF LAST PHYSICAL EXAM_____ ARE YOU HERE BECAUSE OF AN ACCIDENT? YES / NO DATE OF ACCIDENT_____

PREVIOUS SURGERIES_____

LIST OF ALLERGIES_____

LIST OF CURRENT MEDICATIONS_____

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT_____

HIGH BLOOD PRESSURE YES / NO DIABETES YES / NO SMOKE YES / NO DRINK ALCOHOL YES / NO

PRIMARY INSURANCE COMPANY_____

NAME OF POLICY HOLDER_____ EMPLOYER_____

POLICY NUMBER/ID_____ GROUP NUMBER_____

POLICY HOLDER BIRTHDATE_____ RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE COMPANY_____

NAME OF POLICY HOLDER_____ EMPLOYER_____

POLICY NUMBER/ID_____ GROUP NUMBER_____

POLICY HOLDER BIRTHDATE_____ RELATIONSHIP TO PATIENT_____

I AUTHORIZE FREDERICK ENT GROUP TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY AUTHORIZE AND ASSIGN PAYMENTS TO THE PHYSICIAN(S) FOR PROFESSIONAL SERVICES RENDERED. I ALSO UNDERSTAND THAT BY SIGNING THIS FORM I AM FINANCIALLY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED, INCLUDING THE BALANCE REMAINING AFTER INSURANCE BENEFIT PROCESSING AND ANY COST INCURRED BY THE PHYSICIAN(S) IN ORDER TO COLLECT SUCH FEES.

_____ _____

SIGNATURE OF PATIENT / PARENT OR GUARDIAN **DATE**

Patient name_____ **Date of Birth**_____

If you have an insurance copay, it is due and payable **AT THE TIME OF ALL** office visits.

You must have a valid insurance card and referral (if applicable) **AT THE TIME OF YOUR VISIT.** If you do not, you will need to reschedule your appointment or be prepared to pay for today's visit in full. It is your responsibility to know when a referral is required and obtain one **PRIOR** to the visit. Our office **WILL NOT** contact primary care physicians to obtain this.

Due to increased administrative costs, we will charge a $10 fee for excessive paperwork. This includes disability forms, family leave forms, etc.

ALL hearing aids must be paid **IN FULL WHEN DISPENSED.** There are no exceptions to this.

There is a $35 charge for any check the bank returns to us for nonpayment.

My signature below serves as acknowledgment that I have read and understand the above information.

Signature of Patient / Parent or Guardian **Date**

PRIVACY INFORMATION

I grant Frederick ENT Group to:

1. Release personal / medical information to the appropriate insurance / medical entities.

2. Contact me personally at my residence or place of employment. If unavailable, permission is given to leave a message on my answering machine / voicemail, or with a person within my house hold to confirm my appointment, or to notify me of any other pertinent information concerning my care.

3. On the lines below, please list the person(s) (such as family members, power of attorney, or care-taker) that are authorized to have access to my medical / billing information.

_____

_____

_____

My signature below serves as acknowledgment that I have read and understand the above information.

Signature of Patient / Parent or Guardian **Date**