PATIENT INFORMATION FORM

Welcome to Our Office

FREDERICK ENT GROUP
82 Thomas Johnson Court
Frederick, Maryland 21702
Telephone (301) 698-2440

DATE ______________

FAMILY DR. ______________

REFERRED BY ______________

ALL INFORMATION IS STRICTLY CONFIDENTIAL.
(PLEASE PRINT CLEARLY)

PATIENT'S NAME ______ (Last) ______ (First) ______ (Middle) ______ (Nickname) BIRTHDATE ______ (Month. Date, Year)

SOCIAL SECURITY # ______ MARITAL STATUS ______

ADDRESS ______ (Street) ______ (P.O. Box) ______ (City) ______ (State) Zip Code ______

HOME PHONE ( ) ______ WORK PHONE ( ) ______ CELL ( ) ______

EMPLOYER ______

EMPLOYER ADDRESS ______

EMERGENCY CONTACT ______

ADDRESS (if different from patient) ______

HOME PHONE ( ) ______ WORK PHONE ( ) ______ CELL ( ) ______

CHIEF COMPLAINT/REASON FOR VISIT ______ DATE OF ONSET ______

ARE YOU SEEING THE DOCTOR BECAUSE OF AN ACCIDENT? ______ IF YES, DATE OF ACCIDENT ______

DATE OF LAST GENERAL PHYSICAL EXAM ______ (Month-Year) PREVIOUS OPERATIONS ______

LIST ANY ALLERGIES YOU HAVE (drugs, food, hay fever, other) ______

LIST ANY MEDICATIONS YOU ARE TAKING ______

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT ______

DO YOU HAVE HIGH BLOOD PRESSURE? ______ DIABETES? ______

DO YOU SMOKE? ______ DO YOU DRINK ALCOHOL? ______

PRIMARY INSURANCE COMPANY ______

NAME OF POLICYHOLDER ______

EMPLOYER OF POLICYHOLDER ______ SOCIAL SECURITY # ______

POLICYHOLDER'S DATE OF BIRTH ______ GROUP # ______ POLICY/MEMBER # ______

SECONDARY INSURANCE COMPANY ______

NAME OF POLICYHOLDER ______

EMPLOYER OF POLICYHOLDER ______ SOCIAL SECURITY # ______

POLICYHOLDER'S DATE OF BIRTH ______ GROUP # ______ POLICY/MEMBER # ______

I AUTHORIZE THE ABOVE-NAMED PHYSICIAN(S) TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND HEREBY AUTHORIZE AND ASSIGN TO THE PHYSICIAN(S) PAYMENTS FOR PROFESSIONAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS AND ANY COSTS INCURRED BY THE PHYSICIAN(S) IN ORDER TO COLLECT SUCH FEES.

SIGNED ______ (Patient, or Parent if Minor) DATE ______

Your copay is due and payable **AT THE TIME OF ALL** office visits.

Postoperative visits are subject to copays per your insurance company. Because we understand that many copays have risen sharply, we will charge a flat rate of $10 for all postoperative visits unless your specialist copay is less than $10.

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

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

ALL hearing aids must be paid for **in full WHEN DISPENSED.**

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

____

Patient/Guardian Signature   Date

I grant permission to Frederick ENT Group to:

1. Release my 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 household 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 member, power of attorney, caretaker) that are authorized to have access to your medical/billing information.

____

____

____

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

____

Patient/Guardian Signature   Date