PATIENT INFORMATION

Name____ Today's Date_________________________

Mailing Address____

Home Phone(___)____________ Work/Cell Phone (___)____________ SS#______-______-_________

Date of Birth ___/___/___ Age_____ Sex M F Marital Status M S D W

INSURANCE INFORMATION *Present card at time of check-in*

Primary Insurance Name______________________
Primary Ins. Address_________________________
Name of Insured____________________________
Insured's ID#______________________________
Group#____________________________________
Relationship of patient to insured_______________

Secondary Insurance Name_______________________
Secondary Ins. Address__________________________
Secondary Insurance, Name of Insured ____________
Secondary Insurance ID# ________________________
Secondary Insurance Group # ____________________
Relationship of patient to insured

Family members that are patients____

Pharmacy of Choice_________________________ Phone #___________________________
Emergency Contact__________________________ Phone #___________________________
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 to me by physician or supplier. I authorize any holder of medical information about me to release to the CMS and it's agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT 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 and 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 & confusion regarding our 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 the 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 preverified and you will be asked to pay an 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 and debt you have owing our office.

PATIENT OR RESPONSIBLE PARTY______________________________________DATE_____/_____/______