Patient Information Form

First Name _____ Middle Int. _____ Last_____

Date of Birth _____ Gender _____

Address _____ Apt#_____ City_____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Social Security Number _____

Ok to leave confidential voicemail? ☐ Yes ☐ No Email Address _____

List any other person(s) that you would specifically like to be able to access your medical records

Name/Relation _____

_____

INSURANCE INFORMATION: Please present your card to the front receptionist.

Primary Insurance _____

ID# _____ Group# _____

Secondary Insurance_____

ID# _____ Group# _____

If the patient is a minor or the Subscriber ID is someone other than the patient please specify the following

Name of Insured _____ *Birthdate* _____ *Relationship to Insured* _____

All co-payments and referrals are due at the time of service as stated in your insurance contract. If your insurance carrier requires a referral you will need to have that in place before your appointment. If self-pay, payment is due at time of service. If payment plans are needed, please consult the business office. I hereby authorize payment of medical benefits to PDX ENT Audiology Medical Group. I authorize the release of any medical information necessary to process a claim. I acknowledge that I am financially responsible for all charges not covered by insurance, Medicare or Medicaid. I have read and understand the statements above.

No-show and late arrival policy: We request that you give our office a 24 hour notice in the event that you need to reschedule or cancel your appointment. If you do not contact us, we will consider this a no-show. If you know you are going to be late for your appointment, please call and let our office know to see if we can still accommodate your start time. If you do not contact us, we will consider this a no-show. All no-show events will be assessed with a $75 fee that will be billed to you directly and is not covered by your insurance.

By signing, I agree and understand all of the above

Signature _____ Date _____

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