

CAREPOINTE
EAR, NOSE, THROAT & SINUS CENTERS

DATE

ACCOUNT NUMBER						

PATIENT DATA									
LAST NAME			FIRST NAME				MIDDLE NAME		
STREET ADDRESS						AREA CODE	PHONE NUMBER		
CITY				STATE		ZIP CODE			
DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER			SEX:		MARITAL STATUS:		
MO	DAY	YEAR					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
EMPLOYER					EMPLOYER PHONE NUMBER		CELL NUMBER		
HAS ANYONE IN THE FAMILY BEEN SEEN HERE BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO							E-MAIL ADDRESS		
NAME		RELATIONSHIP							

PARENT OR LEGAL GUARDIAN - IF PATIENT IS UNDER AGE 18				
NAME	SOCIAL SECURITY		PHONE NUMBER	CELL NUMBER
ADDRESS	CITY, STATE, ZIP CODE		E-MAIL ADDRESS	
DATE OF BIRTH	EMPLOYER		EMPLOYER PHONE NUMBER	
NAME	SOCIAL SECURITY		PHONE NUMBER	CELL NUMBER
ADDRESS	CITY, STATE, ZIP CODE		E-MAIL ADDRESS	
DATE OF BIRTH	EMPLOYER		EMPLOYER PHONE NUMBER	

SPOUSE INFORMATION - IF MARRIED		
NAME	SOCIAL SECURITY	PHONE NUMBER
ADDRESS	CITY, STATE, ZIP CODE	E-MAIL ADDRESS
DATE OF BIRTH	EMPLOYER	EMPLOYER PHONE NUMBER

INSURANCE INFORMATION		
PRIMARY INSURANCE COMPANY NAME	I.D. NUMBER	GROUP NUMBER
POLICY HOLDERS NAME	DATE OF BIRTH	EMPLOYER
SECONDARY INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER
POLICY HOLDERS NAME	I.D. NUMBER	EMPLOYER

EMERGENCY CONTACT OTHER THAN SPOUSE			
NAME/RELATIONSHIP	ADDRESS	PHONE NUMBER	CELL NUMBER

REFERRAL INFORMATION		
REFERRED BY	ADDRESS	PHONE NUMBER
FAMILY DOCTOR	ADDRESS	PHONE NUMBER

PLEASE CONTINUE ON REVERSE SIDE

WE HEREBY CERTIFY THAT:

1. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements, promptly upon presentment, unless credit arrangements are agreed upon with the office.
2. I hereby authorize the assignment of any insurance benefits and agree to be liable for the payment of all medical services not paid by insurance or other benefits. In addition to the balance left due and owing, I agree to pay all collection costs and reasonable attorney fees in the event this account is turned over to our attorneys for collection, all without relief from valuation and appraisal laws should I fail to pay any amounts owing not paid by insurance or other benefits.
3. I authorize transfer of the above information to Carepointe (In the event audiological services are needed.)
4. I authorize Carepointe to release any medical or other information necessary to process claims.
5. I authorize Carepointe to send appointment reminder postcards through regular U.S. Mail to addresses provided.
6. I authorize Carepointe to leave general messages at any phone numbers or on answering machines, voice mails or e-mail addresses that are provided.
7. I authorize Carepointe to discuss protected health information to the following person(s).
8. I understand that I will be charged a \$25.00 missed appointment fee if I do not give Carepointe 24 hours advanced notice of cancellation.

DATE

SIGNATURE OF RESPONSIBLE PARTY

RELATION TO PATIENT

MEDICARE BENEFICIARIES

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENTS

NAME OF BENEFICIARY

HICN

I request that payment of authorized Medicare benefits be made to either me or on my behalf for any services furnished to me or in Carepointe, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits or benefit related services.

SIGNATURE OF BENEFICIARY

DATE

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENTS

NAME OF BENEFICIARY

HICN

MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made to either me or on my behalf to Carepointe for any services furnished me by that physician/supplier. I authorize any holder of medical or other information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE OF BENEFICIARY

DATE