

NEW PATIENT INFORMATION

Please print neatly. Thank you.

Patient's Name: _____

Patient's Social Security Number: _____

Parent/Caregiver Name: _____

Phone: (home) _____ (work) _____ (cell) _____

The best number to reach you at: home work cell

Patient's Date of Birth: ____/____/____ Age: _____ Gender: M F

Physical Address: _____ City: _____ State: _____ Zip: _____

If different than above:

Mailing Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact _____ Phone _____

Do you authorize release of your medical information to anyone other than yourself? Yes No

If Yes, whom? _____ Relationship _____

CONSULT REQUESTED BY (Referring Physician) _____

Primary Insurance: _____ Policyholder Name: _____

Policyholder ID#: _____ Date of Birth: ____/____/____

Secondary Insurance: _____ Policyholder Name: _____

Policyholder ID#: _____ Date of Birth: ____/____/____

HOW DID YOU HEAR ABOUT US? : _____

Co Pay Amount: _____ (For Office Use Only) Pre Authorization needed? Y or N

IMPORTANT: To avoid delays in the insurance claims process please present your insurance card at your initial visit. All ENT services rendered are charged to the patient's insurance. The patient is responsible for all co pays, deductibles and any charges not covered by insurance. All cosmetic services that are rendered are to be paid at the time of appointment, unless arrangements have been pre-approved by the Office Manager.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Located at the front desk – please ask the receptionist if you would like to review or have a copy)

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices. I hereby authorize Jack D. Sedwick, MD and Christina Magill, MD to provide all information to my insurance carriers concerning my illness and treatments.

Date _____ Signature _____