JACQUELINE JONES, M.D.
NEW PATIENT REGISTRATION FORM
PLEASE PRINT

Date_____

PATIENT INFORMATION

Name(Last, First, MI)_____ Age_____

Gender_____ Date of Birth_____/_____/_____ Marital Status_____

Address_____ Apt#_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Ext_____

Mobile Phone_____ Other Phone_____

Email_____

Mother's Name_____ Father's Name_____

Emergency Contact_____ Phone_____

BILLING: Please complete for guarantor or person responsible for bills.

Name_____ Relation to Patient_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Occupation_____ Employer_____

Home Phone_____ Work Phone_____

INSURANCE INFORMATION: Please note that if your carrier requires Pre Authorization or Pre Approval you are required to obtain prior to your appointment. You may need to check with your carrier if you have a waiting period.

Primary Ins_____ Ins Phone_____

Primary Ins Address _____

Subscriber_____ Relation to Patient: ❑Self ❑Spouse ❑Child ❑Other

Ins ID#_____ Ins Grp#_____

Secondary Ins _____ Ins Phone_____

Secondary Ins Address _____

Subscriber_____ Relation to Patient: ❑Self ❑Spouse ❑Child ❑Other

Secondary Ins ID#_____ Ins Grp#_____

MEDICAL CONTACT INFORMATION: A written report will be sent to your Primary Physician unless otherwise instructed.

Primary Care/Pediatrician_____ Phone_____

Address_____

Pharmacy_____ Phone_____

Address_____

Other Referral Source_____

JACQUELINE JONES, M.D.
Acknowledgement of Financial & Privacy Practice Policies

Dear Patients:

Welcome to our office! Our goal is to provide the highest standard of patient care and it is essential that we establish a clear understanding of our Financial & Privacy Policy with our patients. Should you have questions or concerns about our fees, policy, your financial responsibility or our privacy practices, please do not hesitate to ask.

IN-NETWORK INSURANCE - If Dr. Jones is considered "in-network" with your carrier, you are responsible for all co-payments at the time of service. You may also have in network deductibles and coinsurance and will be billed accordingly.

OUT-OF-NETWORK INSURANCE - We ask for payment in full at the time of service and as a courtesy, we will gladly submit the claim form to your insurance carrier for your reimbursement consideration. Dr. Jones' team is committed to maximizing your insurance benefits and will work closely with you and your insurance carrier. Please contact your insurance company directly for details regarding your out-of-net work coverage.

SELF PAY PATIENTS & INTERNATIONAL INSURANCE - We ask for payment in full at the time of service and will provide you with a receipt for your records.

MEDICARE & MEDICAID PATIENTS - Dr. Jones does not accept Medicare or Medicaid and you will be responsible for payment at time of service. We will also require you to sign a Medicare release form.

REFERRALS - If your insurance company requires a referral to see a specialist, it is your responsibility to obtain this document prior to the appointment. Please remember that referrals expire and you are responsible for renewing with your primary care physician or pediatrician. If you do not obtain a referral, you will be responsible for the entire bill.

CANCELLATION POLICY - We understand that unexpected events occur and we ask that you contact the office as soon as possible to cancel or reschedule your appointment. In the event you do not arrive, the fee is $100.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS - The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Dr. Jacqueline Jones or her staff will not be involved with separation or divorce disputes regarding payment and/or services.

PAYMENT METHODS - We accept Visa, MasterCard, American Express, checks and cash.

AGREEMENT

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Jacqueline Jones or my insurance company to release any information required to process my claims.

I have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Responsible Party Signature_____ Date_____

Print Name_____ Relationship_____

Patient Name_____ Date of Birth_____

How would you like your appointments to be confirmed (Check all that apply):

☐ Home ☐ Cell ☐ Email ☐ Text ☐ Other:_____

JACQUELINE JONES, M.D.
MEDICAL HEALTH HISTORY

Today's Date:_____

Patient Name _____

Patient Date of Birth_____ Age_____ Gender ❑ Male ❑ Female

Occupation:_____Height_____Weight_____

Reason for Consultation

❑ Ear Infection	❑ Sinusitis	❑ Foreign Body in Ear/Nose	❑ Headache	❑ Speech Concern
❑ Ear Aches	❑ Snoring	❑ Sore Throat	❑ Vertigo/Dizziness	
❑ Ear Discharge	❑ Sinus Problems	❑ Swallowing Difficulty	❑ Allergies	❑ Second Opinion
❑ Ringing in Ears	❑ Nasal Obstruction	❑ Mouth/Tongue Sores	❑ Asthma/Wheezing	
❑ Hearing Loss	❑ Nose Bleeds	❑ Thyroid Nodule	❑ Hoarseness	
❑ Earwax Build-Up	❑ Nose Fracture	❑ Neck Mass	❑ Other_____	

Chief Complaint:_____

MEDICATIONS: List ALL medications you are currently taking including herbs, supplements & over the counter medications.

Drug Name (Generic/brand)	Dosage	Frequency	Status
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued
			❑Current ❑Chronic ❑Discontinued

PAST MEDICAL HISTORY: Please provide a complete history including all illnesses, injuries, & surgeries

Illness, Injury & Operations	Date	Treatment	Result

MEDICATION ALLERGIES

Medication Allergy	Reaction

FOOD & OTHER ALLERGIES

Allergic To	Reaction

Other health concerns:_____

_____

Physician Review

Signature:_____Date:_____