NEW PATIENT INFORMATION

Please print neatly. Thank you.

Patient's Name: ____

Patient's Social Security Number: ____

Parent/Caregiver Name: ____

Phone: (home) _________________ (work) __________________ (cell) ____________________

Please circle 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 ____________________________________

(w:newpatinfo)