GrandRapidsENT ear • nose • throat

Welcome to Grand Rapids Ear, Nose, and Throat P.C.

PATIENT INFORMATION (please print) **TODAYS DATE**_____

Legal Name: (last) _____ (first) _____ (MI) _____ Sex: Male / Female

Address: _____City/State: _____Zip:_____

Birthdate: _____ Age: _____ Language Preference: _____ Marital Status: S M D W Sep

Race: □ Caucasian □African American □Hispanic □Asian □Other

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Patients Employer: _____ Work Phone: _____

Spouse's Name: _____ Birthdate: _____

Spouse's Emp.: _____ Work Phone: _____ Cell Phone: _____

Primary Care (family) Doctor? _____ Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____Contact #:_____

PARENT/GUARDIAN INFORMATION – complete if patient is a minor or dependent

Father's Name: _____ Birthdate:_____

Address: _____City/State: _____Zip:_____

Home Phone: _____ Cell Phone: _____ Other: _____

Employer's Name: _____ Work Phone: _____

Mother's Name: _____ Birthdate:_____

Address: _____City/State: _____Zip:_____

Home Phone: _____ Cell Phone: _____Other:_____

Employer's Name: _____ Work Phone: _____

PLEASE NOTE ONLY THE PATIENT AND/OR THEIR LEGAL REPRESENTATIVE SHOULD SIGN THIS FORM. WE REQUIRE A COPY OF ALL LEGAL DOCUMENTS REGARDING GUARDIANSHIP AND CUSTODY.

INSURANCE INFORMATION – please give your insurance card(s) to the receptionist for copying

Primary Insurance_____ **Secondary Insurance**_____

Policy Holder: _____ Policy Holder: _____

Policy #:_____ Policy #:_____

Work-related Injury? Y N Auto Accident Related? Y N How did you hear of us? _____

Patient name_____ **DOB**___

ASSIGNMENT TO PAY INSURANCE BENEFITS/OR PRIVATEPAY:

I certify that the health insurance information provided to Grand Rapids Ear, Nose, and Throat, P.C. by me is valid coverage for this patient. I also hereby assign payment directly to Grand Rapids Ear, Nose, and Throat, P.C. of the group benefits herein specified, including any major medical benefits payable and otherwise payable to me, but not to exceed the physician's regular charges.

I understand that I will be financially responsible for all services provided including:

- **All deductibles and copayments assigned by my health insurance, TO INCLUDE FEES FOR ADDITIONAL SERVICES THAT ARE NOT PART OF THE OFFICE VISIT EXAM. IE: EAR CLEANING, THROAT OR NOSE EXAM WITH A FIBEROPTIC SCOPE, BIOPSY, ETC.**
- **Services that are not a benefit of my health insurance plan**
- **Services not authorized by my managed care insurance plan (or primary care physician).**
- **Any amounts in excess of my insurance payment, in instances where Grand Rapids Ear, Nose and Throat, P.C. does not have contractual, "participating", agreement with my insurance.**

A copy of this authorization may be used in place of the original.

Date: _____ Signature:_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Grand Rapids Ear, Nose, and Throat, P.C. to release medical information to:

- My (or my minor child's) primary care physician.
- The physician requesting the consultation.
- My health insurance carrier or any other source, when necessary to process my medical claim.

A copy of this authorization may be used in place of the original.

Date: _____ Signature: _____

I authorize Grand Rapids Ear, Nose, and Throat, P.C. to give the following people any information on my care when requested by the individual.

_____ _____

_____ _____

A copy of this authorization may be used in place of the original.

Date: _____ Signature:_____