NEW PATIENT INFORMATION

Please print neatly. Thank you.

Patient's Name: _____

Patient's Social Security Number: _____

Parent/Caregiver Name: _____

Patient's Email: _____

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

Please select the best number to reach you at: ☐ ***home*** ☐ ***work*** ☐ ***cell***

Patient's Date of Birth: _____/_____/_____ Age: _____ Gender: ○ M ○ F Ht: _____ Wt: _____

Physical Address: _____City:_____ State: _____ Zip: _____

Occupation: _____ Employer: _____

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 to provide all information to my insurance carriers concerning my illness and treatments.

Date_____ Signature _____