BLUE RIDGE
EAR, NOSE, THROAT
& PLASTIC SURGERY

Federal law requires all healthcare practices to obtain, verify, and record information that identifies each new patient. ***WHAT THIS MEANS TO YOU:*** *When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.*

PATIENT INFORMATION

PATIENT NAME:_____ **AGE:**_____ **SEX:** male/female **DATE:**_____
last first MI

MAILING ADDRESS_____ **EMAIL:**_____ **D.O.B.**___/___/_____

PHYSICIAN: _____
city state zip

PHYSICAL ADDRESS_____ **WHAT CITY/COUNTY DO YOU LIVE IN?**_____
if different from mailing address

SOCIAL SECURITY NO._____
city state zip

HOME PHONE: ( )_____ **REFERRED BY DR.**_____

CELL PHONE: ( )_____ **FAMILY DOCTOR:**_____

PATIENT'S EMPLOYER:_____ **OTHER REFERRAL SOURCE:** circle one below
NEWSPAPER SEMINAR TELEPHONE DIRECTORY
FRIEND TELEVISION OTHER _____

EMPLOYER'S PHONE:_____

IF THE PATIENT IS A MINOR - PLEASE COMPLETE THE FOLLOWING ABOUT THE PATIENT'S PARENTS OR GUARDIANS:

FATHER:_____ D.O.B._____

SOCIAL SECURITY NO:_____

EMPLOYER:_____

WORK PH:_____

MOTHER:_____D.O.B._____

SOCIAL SECURITY NO:_____

EMPLOYER:_____

WORK PH:_____

ARE YOU BEING SEEN TODAY FOR circle one below

ACCIDENT AUTO ACCIDENT ILLNESS WORK RELATED INJURY

IF YOU OR ANYONE IN YOUR IMMEDIATE FAMILY HAVE BEEN SEEN HERE , PLEASE CIRCLE THE DOCTOR'S NAME

DR. COURVILLE
DR. HUTCHISON
DR. MESHKINFAM
DR. CLINE

AND GIVE THE PATIENT'S NAME

_____

EMERGENCY CONTACT: (NOT LIVING IN YOUR HOME)

_____

PHARMACY INFO FOR Rx REFILLS:

_____

PATIENTS' MARITAL STATUS (if patient is a minor, give parents' status)

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SPOUSE'S NAME:_____**D.O.B.**_____

SPOUSE'S SOCIAL SECURITY NO:_____

SPOUSE'S EMPLOYER:_____

SPOUSE'S WORK PH:_____

HEALTH INSURANCE INFORMATION:

☐ **MEDICAID** ☐ **MEDICARE** ☐ **ANTHEM** ☐ **PCHP**
☐ **AETNA** ☐ **CIGNA** ☐ **SOUTHERN HEALTH**
☐ **OTHER:**_____
☐ **MEDICARE HMO**_____

POLICY #:_____
POLICY HOLDER:_____
GROUP #:_____

PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURANCE CARD

PAYMENT IS EXPECTED AT THE TIME OF SERVICE
CO-PAYS ARE DUE AT CHECK-IN

METHOD OF PAYMENT: ☐ CASH ☐ CHECK
☐ MASTERCARD ☐ VISA ☐ DISCOVER

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO BLUE RIDGE EAR, NOSE, THROAT & PLASTIC SURGERY, INC.
I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR PAYING ANY CO-PAY AMOUNT, DEDUCTIBLE AND/OR ANY NON-COVERED SERVICES AT THE TIME OF THE VISIT. FURTHER, I UNDERSTAND AND AGREE THAT IF MY ACCOUNT IS TURNED OVER FOR COLLECTION TO AN ATTORNEY OR COLLECTION AGENCY, I WILL PAY ALL COSTS OF COLLECTION, INCLUDING THIRTY THREE AND ONE-THIRD PERCENT(33-1/3%) ATTORNEY'S FEES, COURT COSTS (INCLUDING SERVICE OF PROCESS COSTS) UNTIL MY ACCOUNT IS PAID IN FULL.

SIGNATURE:_____ ***DATE:***_____