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:_____
last first MI

MAILING ADDRESS_____

_____
city state zip

PHYSICAL ADDRESS_____
if different from mailing address

_____
city state zip

PLEASE CHECK WHICH # BELOW YOU PREFER TO BE CONTACTED ON:

☐ **HOME PH:** ( )_____ ☐ **CELL PH:** ( )_____

PATIENT'S EMPLOYER:_____

EMPLOYER'S PHONE:_____

AGE:_____ **SEX:** male/female **DATE:**_____

EMAIL:_____

RACE:_____ **D.O.B.**_____/_____/_____

WHAT CITY/COUNTY DO YOU LIVE IN?_____

SOCIAL SECURITY NO._____

REFERRED BY DR._____

FAMILY DOCTOR:_____

OTHER REFERRAL SOURCE: **circle one below**
NEWSPAPER SEMINAR TELEPHONE DIRECTORY
FRIEND TELEVISION OTHER _____

PATIENTS' MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED
(if patient is a minor, give parents' status)

SPOUSE'S NAME:_____ **D.O.B.**_____ **SPOUSE SOCIAL SECURITY #:**_____

EMPLOYER:_____ **SPOUSE'S WORK PH:**_____ **CELL:**_____

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:_____ CELL: _____

MOTHER:_____ D.O.B._____

SOCIAL SECURITY NO:_____

EMPLOYER:_____

WORK PH:_____ CELL:_____

EMERGENCY CONTACT: **(NOT LIVING IN YOUR HOME)** **NAME:**_____ **PHONE #**_____

HEALTH INSURANCE COMPANY:_____ **INSURED NAME:**_____

ID # _____ **GROUP #:**_____ **INSURED D.O.B.** _____

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 UP TO FORTY PERCENT (40%) ATTORNEY'S FEES, COURT COSTS (INCLUDING SERVICE OF PROCESS COSTS) UNTIL MY ACCOUNT IS PAID IN FULL.

SIGNATURE:_____ **DATE:**_____

LIFETIME AUTHORIZATION FOR PHYSICIAN SERVICES:

MEDICARE: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Blue Ridge Ear, Nose, Throat & Plastic Surgery, Inc., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable related services.

_____
Patient Medicare Beneficiary Signature **Date**

MEDICARE EXTENDED INSURANCE: I request that payment of authorized Medigap benefits be made on my behalf to Blue Ridge Ear, Nose, Throat & Plastic Surgery, Inc., for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

_____
Patient Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the Privacy Notice. (Version _____)

_____
Patient or Personal Representative's Signature

_____
Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

_____