ADULT PATIENT DEMOGRAPHICS

Last Name ______________________First Name_________________________ Middle_____

Address__________________________________ City ____________ ST____ Zip ________
(No post office boxes)

Home phone (______) _______ - ________ Work phone (______) ________- ___________

Employer_________________________ Occupation__________________________

Emergency contact name________________________________ phone (_____) _____-______

☐ Male ☐ Female Date of birth ____/____/____ Age _____ SSN_____-______-_______

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

* How did you hear about our practice?

____

Referring Physician _________________ Primary Physician _____________________

Phone (___) ______-_________________ Phone (___) _______-___________________

Address __________________________ Address___________________________

***Primary verification (for office use only)** ____

Insurance company ______________________________Phone number________________

Policy number__________________________________Group number________________

Policy holder______________________________Relationship to patient______________

SSN___-_____-______ DOB___/___/___ Employer________________________________

***Secondary Insurance verification**____

Insurance company _______________________________Phone number ______________

Policy number____________________________________Group number_______________

Policy holder_______________________________Relationship to patient______________

SSN ____-____-____ DOB ___/___/____ Employer ________________________________

Patient Agreement

I, the undersigned, am aware that I am financially responsible for all services rendered to me by - Feldman Oringher Dettelbach Mesick & Schoenfeld Otolaryngology, P.C. (the practice)

For those insurances for which the practice accepts assignment,
I am aware that I am personally responsible for all co-payments, deductibles, and non–covered services. As dictated by my insurance coverage.

I, the undersigned, hereby authorize Feldman Oringher Dettelbach Mesick & Schoenfeld Otolaryngology, P.C. (the practice) to apply for benefits for covered services rendered by the Practice, and request that the payments from my insurance carrier and/or Medicare part B be paid directly to the Practice.

I certify that the information I have provided with regard to my identity and insurance coverage is correct, and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier(s) (or in the case of Medicare part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

I, the undersigned, am aware that if at any time my account is sent to an outside collection agency I will be responsible for payment of an additional 30% of the amount sent.

I, the undersigned, am aware that I will be charged a $25.00 no-show fee for any appointment I cancel without a twenty four (24) hr notice

Signature___________________________________Date______________________________

Account #___________