

SHORELINE ENT, PLC

Personal Information

Today's Date: _____ Account #: _____
First Name: _____ MI: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Marital Status: _____
Sex: _____ May we leave information on your answering machine or voicemail? Yes No
Primary Phone: (number you wish to be reached at) _____ Other #: _____
Occupation: _____ Employer: _____ Work No: _____

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

For Minor Patients: Name of Parent/Guardian: _____

Name of Person Filling Out Form: _____ Relationship to Patient: _____

Referring Physician: _____ **Primary Physician:** _____

Insurance Information:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: Self Spouse Child Other

Policy #: _____ Group#: _____ DOB: _____

Employer: _____ Phone Number: _____

Secondary Insurance: _____ Insured's Name: _____

Patient's Relationship to Insured: Self Spouse Child Other

Policy #: _____ Group #: _____ DOB: _____

Employer: _____ Phone Number: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I hereby authorize SHORELINE E.N.T., PC to disclose any medical records to my insurance company, employer, or acting intermediary for payment benefits.

I have read the above information and understand that I am responsible for payment for services I receive.

PATIENT IS RESPONSIBLE FOR RE-SCHEDULING ALL MISSED APPOINTMENTS AND OR OUTPATIENT SERVICES.

Patient/Guardian Signature: _____

Date: _____