

Date _____
Patient's Name _____
Age _____ (last) _____ (first) _____ (MI)
Date of Birth _____ Sex: M F S M W D
(marital status)

Street Address _____
City _____ State _____ Zip _____
Home Phone: _____ Social Security# _____
Spouse _____ Social Security# _____
Employer (self) _____ Employer Phone# _____
Employer (spouse) _____ Employer Phone# _____
Parents (If a minor) Child resides with: (circle) Mother Father Both Other _____
Father _____ Social Security# _____
Mother _____ Social Security# _____

Address: (if different than above) _____
City _____ State _____ Zip _____ Phone: _____
Employer(Father) _____ Employer Phone# _____
Employer(Mother) _____ Employer Phone# _____

Have you or immediate family members been seen by our doctors before: Yes No
Whom? _____ Who shall we contact in an emergency? _____
Relationship _____ Phone _____

Nature of Illness _____
Drug Allergies (if none, put none) _____
Referring Doctor _____ Family Doctor _____
Primary Insurance Company _____

(Subscriber's Name) Policy # (Subscriber's Birthdate)
Secondary Insurance Company _____

(Subscriber's Name) Policy# (Subscriber's Birthdate)

It is your responsibility to determine if our services are covered under your insurance plan. I understand that I am financially responsible for all charges whether or not paid by insurance and that interest will be charged at a rate of 1.5% per month on balances over 60 days. I authorize the doctor to release all information necessary to secure the payment of insurance benefits. I authorize insurance payment of medical benefits to Otologic Medical Services, P.C.

_____ Date _____

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(to be filed in the patients medical records)

I have been presented with a copy of the NOTICE OF PRIVACY PRACTICES, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature Date Relationship (if not signed by patient)

I wish to place the following restrictions of disclosure of my health information:

INTERNAL USE ONLY

If patient/ patient's representative refuses to sign acknowledgement, please document date and time notice was presented to the patient and sign below:

Presented on (DATE AND TIME) _____ By (name and title) _____