

# PATIENT INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. *Thank you!*

## PATIENT INFORMATION

Name (First, Middle Initial, Last) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female Marital Status: S M W D

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Alternate: ( ) \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

## RESPONSIBLE PARTY

(Please give the information for the person who is, the policyholder of the insurance or if the patient is a child please give the information for the person who is the responsible for financial issues. )

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Home Phone Number: ( ) \_\_\_\_\_ Work Number ( ) \_\_\_\_\_

## IF PATIENT IS A CHILD

Parent/Guardian 1 \_\_\_\_\_ Daytime Contact: ( ) \_\_\_\_\_

Parent/Guardian 2 \_\_\_\_\_ Daytime Contact ( ) \_\_\_\_\_

## LOCAL EMERGENCY CONTACT

Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Daytime Contact: ( ) \_\_\_\_\_

## **ASSIGNMENT OF BENEFITS/AUTHORIZATION**

I hereby assign payment directly to Carolina ENT, PLLC of the surgical medical and/or major medical benefits, if any, otherwise payable to me for the professional services rendered in the course of any examination of treatment. This authorization shall remain valid until revoked in writing.

---

Signature: (Insured)

Date

## **RESPONSIBILITY FOR PAYMENT OF MEDICAL SERVICES**

I understand that Carolina ENT, PLLC will file my insurance as a courtesy. However, I am ultimately responsible for all medical fees relating to my care. Should my insurance deny for any such reasons as; an authorization, deductible, or non-covered service, I understand that I will be responsible for my bill.

---

Signature: Patient or Responsible Party if Patient is a Minor

Date

## **NOTICE OF PRIVACY PRACTICES**

I understand that Carolina ENT's Notice of Privacy Practices informs me of how my medical information may be used pertaining to treatment, payment and healthcare operations. My signature signifies that I have received a copy of this notice.

---

Signature: Patient or Responsible Party if Patient is a Minor

Date

03/10/04

In order to better serve our patients, their families and comply with federal government's privacy act, we ask that you list below who you give Carolina ENT permission to discuss your medical information with:

---

Name

Relationship

---

Name

Relationship

---

Name

Relationship

If at any time you decide to add/remove anyone from this list, you will need to contact us in writing or in person.

## NEW PEDIATRIC PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Age \_\_\_\_\_ Today's date: \_\_\_\_\_ Referring doctor: \_\_\_\_\_  
Family doctor: \_\_\_\_\_

How did you find out about us? \_\_\_\_\_ Referred by another doctor \_\_\_\_\_ Telephone book \_\_\_\_\_  
Referred by a friend (name) \_\_\_\_\_

### Chief Complaint

What is the main reason for today's visit? \_\_\_\_\_

Any other current health problems? \_\_\_\_\_

### Past Medical History (Please describe any conditions that apply to your child):

Allergies \_\_\_\_\_ Ear Disease \_\_\_\_\_ Pneumonia \_\_\_\_\_

Asthma \_\_\_\_\_ Bronchitis \_\_\_\_\_ Premature birth \_\_\_\_\_

Other \_\_\_\_\_

### Past Surgical History

Please list any previous surgeries with approximate dates: \_\_\_\_\_

\_\_\_\_\_

### Social History

Is your child in daycare? \_\_\_\_\_ Does anyone in the family smoke? \_\_\_\_\_

If your child is in school, what school and what grade? \_\_\_\_\_

Any problems at school? \_\_\_\_\_

### Medications

What medications does your child take? (indicate dosages if known): \_\_\_\_\_

\_\_\_\_\_

Has your child ever had an allergic reaction to a medicine? (which medicine, what kind of reaction?):

\_\_\_\_\_