The Centers for Advanced ENT Care - North Bay ENT & Audiology - Patient Detail Sheet

Patient ID#:
Patient Name:
Address 1:
Address 2:
Address 3:
Physician:
Referring Dr:
Primary Care:
Sex: DOB:
Home Phone:
Cell Phone:
Work Phone:
Emergency Info:
Social Security:

Email:
_____ I do not wish to provide my email
Reason: _____

Primary Insurance
Insurance:
Insured Name:
Policy Holder:
DOB:
Policy Number:
Group Number:

Secondary Insurance
Insurance:
Insured Name.
Policy Holder:
DOB:
Policy Number:
Group Number:

Notice of Privacy Practices (HIPAA):
I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.
____ Yes, you may speak with any member of my family and/or these individuals _____
____ No, do not speak with my family/friends about my healthcare unless I give you permission.

Health Information Exchange Acknowledgement for CRISP Access:
(Chesapeake Regional Information System for Our Patients)
I have received, read and understand what the CRISP system is used for. I understand that Drs. Gehris, Jordan, Day and Associates participates with CRISP and their health information exchange.
____ Yes, you may access my health information through CRISP.
____ No, you may not access my health information throuhg CRISP and I would like an Opt-Out Form (____)

Have you seen any other ENT physicians in the last 3 years? If so, who_____

Patient's Authorization:
I authorize Drs. Gehris, Jordan, Day and Assocaites, LLC to apply for benefits on my behalf for covered services rendered. I request that payments from my insurance company be made directly to Drs. Gehris, Jordan, Day and Associates, LLC. I certify that the information I have reported with regard to my insurance coverage is correct and firther authorize the release of any information, including medical information for this or any related claim, to the above billing agent. I permit a copy of this authorization to be used in place of original. This authorization my be revoked by either me or the above named carrier at any time in writing. I consent to the treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring family physicians and to my insurance company if applicable. I understand the payment of chaged incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. I have read and fully understand the above consent for treatment, financial responsibility, release of medical record information, and insurance authorization.
Date: _____/_____/_____ Signature: _____