

# ADULT

## PATIENT INFORMATION – PLEASE PRINT

### PATIENT:

_____	_____	_____
Last Name	First Name	Middle
_____	_____	_____
Address	City / State / Zip	
Sex: Male / Female (circle one)	_____	_____
	Home Phone	Cell Phone
_____	_____	_____
Date of Birth	Social Security Number	E-Mail
_____	_____	_____
Name of Employer	Occupation	Work Phone

### INSURED (SPOUSE/PARENT or GUARDIAN/OTHER):

_____	_____	_____
Last Name	First Name	Middle
_____	_____	_____
Address (if different)	City / State / Zip	
_____	_____	_____
Home Phone (if different)	Cell Phone	Social Security Number
_____	_____	_____
Name of Employer	Work Phone	Date of Birth

### INSURANCE:

_____	_____
Primary Insurance Company	Secondary Insurance Company
_____	_____
Policy Holder's Name	Policy Holder's Name

### OTHER:

Has any other member of your family been seen in our office? Yes / No  
If so, please list them: \_\_\_\_\_

In case of an emergency please notify:

_____	_____	_____
Name	Relationship	Phone Number

**PRESENT PHOTO ID AND ALL INSURANCE CARDS TO THE RECEPTIONIST**

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Current Problem \_\_\_\_\_

Number of occurrences of this problem within the past 12 months \_\_\_\_\_

Have any x-rays, CT's, MRI's been obtained relative to the current problem? Yes / No

If so, when and where \_\_\_\_\_

Referring Doctor: Name, Town and Phone \_\_\_\_\_

When was the last time you had your hearing tested? \_\_\_\_\_

**List current medications and specify dosage  
(Prescription, herbal, OTC, birth control, aspirin)**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Do you have any allergies? \_\_\_yes \_\_\_no  
If yes, please list them (include allergies to  
medications and their adverse reaction).**

**List all Past Surgeries**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<b><u>FOR OFFICE USE ONLY:</u></b>
_____
Patient Account Number

**FOX VALLEY EAR, NOSE AND THROAT ASSOCIATES, S.C.**

Authorization for Payment & Insurance Information, Consent for Release & Use of Confidential Information, and Receipt of (or opportunity to review) Notice of Privacy Practices

**Authorization for Payment & Insurance Information:**

I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. If Fox Valley Ear, Nose and Throat Associates, S.C. is not a participating provider for my plan, I will pay in full at the time of service. It is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

1. I will provide Fox Valley ENT with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.
2. I will pay for all applicable co-pays and outstanding patient balances as they become due. I understand that Fox Valley ENT is not a representative of my insurance company, and therefore, cannot guarantee benefits quoted or paid. If I have questions about my benefits I will contact my insurance company directly.
3. For a work-related injury Fox Valley ENT will bill my worker’s compensation carrier only if written approval is received from my employer. However, I understand that I must also give my medical insurance card in case of the claim being denied.

I understand that any patient balances not paid after 90 days will be assessed with a \$10 finance charge each month the balance remains unpaid. I will be responsible for all costs of collecting monies owed, including interest, court costs, and collection agency and attorney fees. I will also be responsible for bank fees from returned checks.

**Consent for Release & Use of Confidential Information:**

I hereby authorize Fox Valley Ear, Nose and Throat Associates to release all information necessary to secure payment for all services performed by David S. Hemmer, M.D., Rockne L. Brubaker, M.D., or Glen K. Lochmueller, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid original.

**Notice of Privacy Practice:**

I have been given the opportunity to review the Notice of Privacy Practices, and a copy has been made available to me.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Signature (Patient or Guardian)

\_\_\_\_\_  
Relationship to Patient (if other than self)

\_\_\_\_\_  
Today’s Date