

MIDDLETOWN COMMONS B-9

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BELLTOWER PLAZA 576 Metacom Avenue, Unit 6, Bristol, RI 02809 Telephone (401) 254-4327

www.earnosethroatmed.com

PATIENT NAME:		DATE OF BIRTH:			
HOME ADDRESS:		MALE/FEMALE:			
CITY/TOWN:	STATE:ZIP:				
	CELL PHONE :CHECK PREFERRED NUMBER				
E-MAIL ADDRESS:					
PLEASE CIRCLE PREFERRED MET	THOD OF CONFIRMATION: P	HONE TEXT E	MAIL		
LAST 4 DIGITS OF SOCIAL SECURITY	Y NUMBER:	MARITAL STATUS:	M S O		
PREFERRED LANGUAGE:	RACE/ET	THNICITY:			
PATIENT EMPLOYER:		OCCUPATION:			
IS THE PATIENT A STUDENT? YES	S/NO FULL / PART TIME IF	SO, WHERE?			
	**************************************	TIVE, OR FRIEND)			
NAME:	RELATIONSHIP:	PHONE:			
ADDRESS:	CITY/TOWN:	STATE:ZIP	:		
***********	**********	********	*****		
PRIMARY CARE PHYSICIAN NAME	Ε:				
PHYSICIAN REQUESTING THIS CO	ONSULTATION:				
PHARMACY NAME & TOWN:					
HOW DID YOU HEAR ABOUT US?					

PCP HEALTH INSURER

MEDICAL INSURANCE COVERAGE INFORMATION

	DO Y	OU HAVE MEDICARE?	YES	NO	MEDICARE#:	
*IF SO, Do you or your spouse work?		YES	NO			
	* IF SO , Does that employer provide health coverage for you?		YES	NO		
* IF SO , Please list name of employer: *Medicare requires this information for coordinate		* IF SO , Please list name of employer: care requires this information for coordination of	of benefit	s if appl	cable	
DO Y	OU HA	VE BLUE CROSS PLAN 65?	YES	NO	B/C65#:	
D0 1						
	DO Y	OU HAVE STATE MEDICAID?	YES	NO	MEDICAID#	
		OU HAVE COVERAGE THAT T LISTED ABOVE?	YES	NO		
	1.	COVERAGE NAME AND ADDRESS:				
		POLICY#:OFFICE VISIT COPAY:DEDUCTIBLE:				
		NAME OF SUBSCRIBER'S DOB:				
		SUBSCRIBER'S EMPLOYER:WORK PHONE#				
	NAME OF SECOND MEDICAL COVERAGE IF ANY					
					_OFFICE VISIT COPAY:	
		NAME OF SUBSCRIBER:			SUBSCRIBER'S DOB:	
		SUBSCRIBER'S EMPLOYER:			WORK PHONE#	
****	*****				***********	
AUT		ATION AND RELEASE				
ovem		•	_		gnosis and the records of any treatment or	
				_	y payors and/or other health care practitioners ny electronic medical information pertaining to	
		e including but not limited to prescriptions,				
			pay dire	ctly to	the doctor or doctor's group insurance benefits	
other		able to me.	a than th	o ootus	I hill for conviges. Lagree to be responsible for	
pavm		• • • • • • • • • • • • • • • • • • • •			I bill for services. I agree to be responsible for amples: insurance deductibles, co-pays and co-	
insura		and the second of the second where the	j 00 0	, <u></u> ,		
		-	•		minor child and to communicate to me or my	
design	nated hea	alth care provider findings/results of my exa	m via le	tter, fax	x, email, or telephone.	

SIGNED: _____DATE: ____