PERSONAL INFORMATION

Name: ______________________________ Date: ____________________

Address:____

City, State, ZIP code: ______________________________________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ FAX Number: ____________________

E-Mail: ____

Birthdate: ______________ Social Security Number: ____________________

❑ Male ❑ Female ❑ Minor Drivers License #: ____________________

Employer: ____

Occupation:____

❑ Single ❑ Married ❑ Divorced/Separated ❑ Widowed

Where do you prefer to receive phone calls? ❑ Home ❑ Work ❑ Cell

When is the best time for you to receive calls? ____________________

*Emergency Contact Information: (In the event of an emergency, who should we contact?)

Name: ______________ Relationship: __________ Phone:______________

INSURANCE INFORMATION

______________________________	______________________________
PRIMARY INSURANCE COMPANY	SECONDARY / TERTIARY INSURANCE COMPANY
Name of Insured: ______________	Name of Insured: ______________
Relationship to Patient: ______________	Relationship to Patient: ______________
Insured's Birthdate: ______________	Insured's Birthdate: ______________

*Please Note: East Valley ENT is ONLY contracted with **Medicare, Blue Cross*, and Blue Shield*** at this time. All other insurance companies are considered Out-of-Network or Non-Preferred providers and the patient/responsible party may be responsible for a higher percentage of the bill than if treated by an In-Network or Preferred provider. (*PPO only. Certain plans may have restrictions – ask office staff for more info)*

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment, or examination rendered to me or my child during the period of such care to third party payors and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

X ____

Signature of Patient (or parent/guardian, if the patient is a minor)

EAST VALLEY ENT

Warren S. Line Jr., M.D.

PRIVACY NOTICE

ACKNOWLEDGEMENT OF RECEIPT

By my signature below, I acknowledge that I have read and/or received a copy of this office's HIPPA (Health Information Portability and Accountability Act) Privacy Notice, and that a copy is available to me at any time.

I have listed the name(s), relationship(s), and phone number(s) of persons I authorize to receive my protected health information. (Please indicate if none)

❏ NONE – I do NOT authorize additional access to my protected health information at this time.

❏ NAME: ______________________________ PHONE #: ______________________

RELATIONSHIP: ______________________

❏ NAME: ______________________________ PHONE #: ______________________

RELATIONSHIP: ______________________

❏ NAME: ______________________________ PHONE #: ______________________

RELATIONSHIP: ______________________

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____

Patient or Authorized Representative Name **(Please Print)**

X: ______________________________________ ______________________

Patient or Authorized Representative Signature: Date of Signature

❏ Patient Refused to Sign ❏ Patient/Representative unable to sign because:

____

Effective date of this notice: APR 15, 2003 / Contact Person: Gabriel – Office Manager / Office Phone Number (818) 559 - 9727

Name: ______________________________ Date: ______________

Current Physicians

Primary Care Doctor Name: ______________________________

Other Doctor #1 Name: ______________________________

Other Doctor#2 Name: ______________________________

Current Medication List

You do NOT need to indicate the prescribing physician or detailed dosage info
Please include Over The Counter Medicines or Supplements that you take

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________
13. ______________________
14. ______________________
15. ______________________
16. ______________________

Allergies/Sensitivity to Medications

❑ NKDA – I have no known drug allergies.

❑ YES – I am allergic /sensitive to: ______________________________