SCENT
ALLERGY & SLEEP MEDICINE

Patient Information Form

Todays' date: MM/DD/YYYY **Account #**_____

Patient's First Name_____Middle Name _____ Last_____

Gender: _____ DOB: MM/DD/YYYY Marital Status: _____ SSN: _____

Address: _____ City/State/Zip: _____

E-mail: _____ ▯ _____ ☎ _____ Leave message on voicemail? **YES** or **NO**

Preferred communication method: □ E-mail □ Cellphone/text □ Home phone □ US Mail

Race: _____ Preferred Language: _____

Please list any known drug allergies: _____

Initial here if NO known drug allergies: _____Is the patient allergic to latex? **YES** or **NO**

Emergency Contact/HIPAA Contact Name: _____Relationship: _____ Phone #: _____

Responsible Party Name: _____ DOB: _____ SSN#: _____

Primary Phone: _____ Work Phone: _____ E-mail: _____

Employer: _____ Occupation: _____

Primary Insurance: _____ Policy #: _____

Policyholder Name: _____DOB: _____SSN#: _____

Patient Relationship to Policyholder _____Self _____Spouse _____Child _____Other

Secondary Insurance: _____ Policy #: _____

Policyholder Name: _____DOB: _____SSN#: _____

Patient Relationship to Policyholder _____Self _____Spouse _____Child _____Other

Billing Preference, please check: _____ Mail/Paper: _____ E-mail: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If SCENT is filing an insurance claim for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide complete information and/or a required referral, we will be unable to file your insurance and payment in full will be required at the time of the visit.

Patient financial responsibility for insured patients may be estimated, but not confirmed until the claim is processed by your insurance company. Patients' financial responsibility will be based on your individual health insurance plan. Any amount applied to your plan deductible and/or co-insurance by your insurance company will be your financial responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your financial responsibility. Your office visit co-pay is due at the time of your visit and, in many cases, may not cover the entire office visit charge. Any procedures performed may be considered surgery by your insurance company, in which case surgical deductibles and co-insurance may apply.

For all other patients, including uninsured patients, payment is required at the time of service. Your initial visit payment may not cover all services provided during your visit and may require additional payment for which you are responsible. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand I am responsible for payment for all services received.

Patient/Guardian/Guarantor Signature: _____

Patient/Guardian/Guarantor Printed Name: _____Date: MM/DD/YYYY