PATIENT DEMOGRAPHIC SHEET

PLEASE COMPLETE ENTIRE FORM
WE REQUIRE ALL PATIENTS TO SHOW THEIR INSURANCE CARD(S) AND A PICTURE ID

PATIENT INFORMATION

First Name: ______________________ MI: ______ Last Name: _________________________
DOB: ____/____/_____ Age: ____ SSN:____-____-_____ Gender: _____
Mailing Address: ____________________________ City: ______________ State: _____ Zip: ________
Primary Phone:______________ Work Phone: ______________ Mobile/Other Phone: _______________
How do you prefer to be contacted: (circle) text call email
Email address: ____________________________
Referring Physician: ________________________ Family Physician: ________________________
Pharmacy Preferred: ___________________ Address (specific street and city): _____________________

EMERGENCY CONTACT

First Name: _______________________ Last Name: __________________________
Address: __________________________ City: _________________ State: _____ Zip: ________
Primary Phone: _____________________ Relationship: _____________________

*****REQUIRED FOR PATIENTS UNDER 18*****

GUARANTOR'S INFORMATION

Mother's First Name: _______________________ Last Name: _______________________
Address: __________________________ City: _________________ State: _____ Zip: ________
SSN: ____-____-_____ ***(SSN is required for at least one parent)*** DOB: ____/____/_____
Primary Phone:______________ Work Phone: ______________ Mobile/Other Phone: _______________
Employer: ____________________ Is this the patient's emergency contact? (circle) Yes or no

Father's First Name: _______________________ Last Name: _______________________
Address: __________________________ City: _________________ State: _____ Zip: ________
SSN: ____-____-_____ ***(SSN is required for at least one parent)*** DOB: ____/____/_____
Primary Phone:______________ Work Phone: ______________ Mobile/Other Phone: _______________
Employer: ____________________ Is this the patient's emergency contact? (circle) Yes or no

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INSURANCE INFORMATION

Primary Insurance Carrier: _____________________________
Secondary Insurance Carrier: ___________________________

*****PAYMENT IS DUE FOR ALL OFFICE CHARGES ON THE DAY OF THE EXAMINATION*****

- I hereby authorize, assign, and direct payment of basic and major medical benefit directly to ENT & Allergy Associates of South Georgia. I understand that I am responsible for any amount not covered by insurance. If my insurance has not paid any claim within 45 days, I will be responsible for any cost incurred by ENT & Allergy Associates for the recovery of this account.
- I also authorize the release of any information needed to determine benefits payable for related services. A photocopy of this authorization is as valid as an original.

Patient Signature or Guarantor: ______________________________
Date: _____/_____/_______

PATIENT CONFIDENTIALITY

ENT & Allergy Associates of South Georgia follows HIPAA guidelines to ensure the integrity of your privacy. We need your help in ensuring your privacy by providing us with the following information. In the event that I, ______________________ cannot be reached personally, ENT & Allergy may leave any test result, lab result, appointment information, or other confidential medical or financial information to the following designated individuals:

Name	Relationship to Patient	Date of Birth (mm/dd)	Contact Phone	Emergency Contact (Y/N)

Release of your protected health information (PHI) to anyone other than the patient or parent/legal guardian will be restricted to those individuals listed above or individuals otherwise listed on the Notice of Privacy Practices.

PATIENT SIGNATURE: ____ DATE: ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been made aware of ENT & Allergy Associates' Notice of Privacy Practices and acknowledge that it is posted in the waiting room, available on the website (www.entofsouthgeorgia.com) and I may request a paper copy of the privacy notice at this location. I understand that I may address any questions or concerns I may have about the Notice to the Practice's Compliance Officer.

Signature of Patient:

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Signature of Guardian or Representative (if executing on behalf of the patient):

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Patient's Printed Name:

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Guardian/Representative's Printed Name:

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PATIENT PORTAL ACCESS TO MEDICAL RECORDS

ENT & Allergy Associates of South Georgia allows you to access your medical information through our Patient Portal. If you would like to have access to your Patient Portal, we will send an e-vite to the email address below. Once you receive the e-vite, click on the link and follow the instructions.

email address: _______________________________________

ENT & ALLERGY ASSOCIATES OF SOUTH GEORGIA

2910 N. Patterson Street
Valdosta, GA 31602

FINANCIAL POLICY

We are committed to providing you with the best possible patient care. Our goal is to keep your financial responsibilities as simple as possible.

- If you have insurance, we will file it as a courtesy to you. All co-payments, co-insurance and ***estimated*** patient portions for surgeries or in-office procedures will be due at "time of service."
- Your insurance policy is an agreement between you, your employer and the insurance company. It is your responsibility to understand what services are covered, if you are in or out-of network, have a deductible, or require authorization to be seen, etc. If payment is not received within 60 days from the date of service, you will be expected to pay the balance in full.
- Any outstanding account balances from previous appointments will be collected before your appointment. For your convenience, we accept cash, checks, credit cards, and Care Credit.
- You may now pay your balance from the patient portal under "My Account" or our website www.entofsouthgeorgia.com.
- Non-payment may result in the rescheduling of your appointment.
- Statements are mailed monthly for unpaid balances. It is the responsibility of the patient to monitor outstanding balances and pay accordingly. If there are any questions concerning any balance, ***please call our billing office at 229-244-2562 ext. 236.***
- It is your responsibility to provide us with your current address, primary contact phone number and insurance information at each visit. If you do not have proof of your current insurance at your visit, you will be considered a self-pay patient and payment will be due in full.
- Balances older than 60 days are subject to collection fees up to 35% of balances due. Patient accounts submitted to a collection agency are also considered dismissed until all balances are paid in full.
- All returned checks will be subject to an additional $35.00 collection fee.

Patient Name: ________________________

I acknowledge that I have read, understand, and agree to the policies and procedures outlined above.

Patient Signature: _________________________
Date: ____________

LIST OF CURRENT MEDICATIONS

Name: ____________________________ Date: ___________________

Medication (Brand and/or Generic Name)	Dose	How often do you take the medication?

List any medication allergies:

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