Patient Information

Date of Office Visit: **Name FIRST: MI: LAST:**	**DOB: Age: Sex: M F**
Address:	**Phone: SS#** **Cell Number:**
City: State: Zip:	**Employment:**
Race: Ethnicity: Language:	**Employer: Phone:**
Marital Status:	**Pharmacy: City:**
Primary Care Physician:	**Parent / Guardian: DOB:**

Please Bring Insurance Cards to your Appointment

Insurance Company:	**Policy #: Group#:**
Primary Subscriber : **Relationship to Subscriber: Spouse Self Child**	**DOB:**
Secondary Insurance:	**Policy #:**
Secondary Subscriber:	**DOB:**

Please List Current Medications (*Dosages and Times Taken)* *May use the back or attached list*

Name of Medication	Dosage	How often taken

Please list any medications allergies | Reaction

Previous Surgeries (Please include dates)

Have you had any problems with anesthesia (numbing or put to sleep) _____Yes _____ No

If yes, please list problems: ____

Please list non-surgical hospitalizations *(reason and date)*

____

Other History (Circle Yes or No)

Have you had a pneumonia vaccine? **Yes** or **No** (Date if **yes**) ______ Have you had an influenza vaccine? **Yes** or **No** (Date if **yes**)_____Have you had a colonoscopy cancer screening? **Yes** or **No** (Date if **yes**) ______ Have you had a Breast Cancer Screening? **Yes** or **No** (Date if **yes**)_________

Reason for visit (**Please list when symptoms started and any other pertinent information)**

Patient Printed Name: ______________________________ Date of Birth:________________

HIPAA Privacy Practice

Initial: ____ I acknowledge that a copy of Valley Facial Plastics & ENT's Notice of Privacy Practices is posted in the waiting room and is available upon request.

Notice of Disclosure of Fee/Payment Policy

Initial: _____ I understand that I am responsible for the payment of all services rendered. Valley Facial Plastics & ENT participates in most insurance plans and will file your insurance for all plans. We do require all co-payments be paid in full at the time medical services are rendered. If there is a remaining balance after your insurance carrier pays, you will be billed and payment is due upon receipt. Self pay patients are required to pay at the time of service. Payments made in full are eligible for a 20% discount (this discount does not apply to the purchase of hearing aids and hearing aid accessories and other supplies or medications). If you cannot pay in full, we require a $100 deposit for all new patients and $50 for established patients. If you need to make special payment arrangements, it is your responsibility to contact the billing department prior to your appointment.

Multi-Specialty Practice

Initial: ____ I am aware that Valley Facial Plastics & ENT is a multi-specialty practice, and that I may be billed for more than just an office visit. Additional charges may include audiometry, binocular microscopy, cerumenectomy, nasal cautery, laryngoscopy, injection of medications, biopsy, fine needle aspiration, post surgical debridement and ultrasound. These are not inclusive of all the additional charges that may be billed separately from an office visit. I understand that the cost of care will be based upon treatment rendered at the time of service.

Patient Consent to Treat and Obtain Medical/Medication History Electronically

Initial: ____ I authorize Valley Facial Plastics & ENT to request and use medication and medical information electronically from pharmacies and other healthcare providers that may be used in my care at Valley Facial Plastics & ENT.

Patient/Guardian Signature: ______________________________________ Today's Date_____________

Medicare Lifetime Assignment and Medigap Authorization

THIS SECTION APPLIES TO MEDICARE PATIENTS ONLY.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Valley Facial Plastics & ENT for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap (my secondary insurance carrier) be made either to me or on behalf to Valley Facial Plastics & ENT for any services furnished me by that provider. I authorize any holder of medical information about me to release to ________________________ (name of secondary insurance carrier) any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: ______________________________________ Today's Date_____________