

Chart #(Office Use Only): _____

Associates in Ear, Nose and Throat of Greater Nashua

Patient's Name _____ Primary Care Physician _____
Street or PO Box _____
City _____ State _____ Zip _____
Telephone _____ Sex _____ Age _____ Date of Birth _____
Cell Phone _____ Social Security # _____ Marital Status _____
Medications Allergic to _____
Employed by _____ Telephone _____
Employers Street or PO Box _____
City _____ State _____ Zip _____ Occupation _____

Parent/Guardian (if patient is under 18)

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Social Security# _____ Home Phone _____ Work Phone _____
Employed by _____ Telephone _____
Employers Street or PO Box _____ Occupation _____
City _____ State _____ Zip _____

In Case of Emergency

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Phone _____

Insurance Information

Name of Primary Insurance Company _____
Policy Holder's Name _____ Date of Birth _____ Relationship _____
Name of Secondary Insurance Company _____
Policy Holder's Name _____ Date of Birth _____ Relationship _____

I understand that health insurance is designed to help me meet the cost of medical service, but the responsibility for payment is mine. I authorize release of any medical information necessary to process my insurance claims. I authorize direct payment of benefits to Associates in Ear, Nose and Throat of Greater Nashua. A photocopy of this authorization shall be as valid as the original.

Signature _____ Date _____

FOR MEDICARE RECIPIENTS ONLY:

MEDICARE BENEFICIARY'S LIFETIME PAYMENT AUTHORIZATION:

I request payment of authorized benefits be made to me or on my behalf to Associates in Ear, Nose and Throat of Greater Nashua for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits for related services.

Signature _____ Date _____

HIPPA Acknowledgment:

In order to prevent any possible delays, I agree to allow Dr. Donovan's office to leave messages regarding laboratory and x-ray results as well as office appointments on my answering machine. Yes _____ No _____

I have been offered the HIPPA information pamphlet "Notice of Privacy Practices".

Signature: _____ Date: _____

Payment Policy: We ask that you be prepared to pay for services at the time they are rendered . Should you have any questions regarding fees or billing , we encourage you to inquire beforehand.