

DAYTON HEAD & NECK SURGEONS

PATIENT INFORMATION

Name (Last) _____ (First) _____ Initial _____

SS# _____ Date of Birth _____ Age _____

Address _____

City / State / Zip _____

Married Widowed Divorced Single Male Female

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Phone _____ Name _____

Relationship to Patient _____

Employed: Yes No Retired Full-time Student Part-time Student

Employer: _____

Referring Doctor's Name (Last) _____ (First) _____ City _____ Phone _____

Family Doctor's Name (Last) _____ (First) _____ City _____ Phone _____

PERSON RESPONSIBLE FOR PAYMENT OTHER THAN PATIENT (Only one per family)

Name (Last) _____ (First) _____ Initial _____

Address _____ City / State / Zip _____

Home Phone _____ Work Phone _____ Birthdate _____

SS# _____ Employer _____

Relationship to Patient _____ If retired, from _____

MEDICAL INSURANCE INFORMATION (Please give clerk your insurance cards so we can make copies for our records.)

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers. Please show all numbers on your card(s). This will eliminate billing to you because of incomplete information.

PATIENTS WITH MEDICARE: Is your spouse actively working and have health insurance coverage: YES NO

PRIMARY INSURANCE CO. _____

Cardholder's Name _____ Patient's Relationship to Cardholder _____

I.D. # _____ Group # _____

Cardholder's Birthdate _____ SS# _____

SECONDARY INSURANCE CO. _____

Cardholder's Name _____ Patient's Relationship to Cardholder _____

I.D. # _____ Group # _____

Cardholder's Birthdate _____ SS# _____

I authorize **Dayton Head & Neck Surgeons, Inc.**, to provide diagnostic and treatment services to me. All rendered services, including any changes or updates in existing treatment, will be discussed with me prior to their implementation.

I authorize **Dayton Head & Neck Surgeons, Inc.**, to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier to issue payment check(s) directly to **Dayton Head & Neck Surgeons, Inc.**

I authorize **Dayton Head & Neck Surgeons, Inc.**, to furnish complete information to my insurance carriers or its intermediaries regarding services rendered.

A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

My signature indicates my consent for treatment and that the information I have provided is correct.

Signature of Patient/Parent/Legal Guardian _____ Date _____

DAYTON HEAD & NECK SURGEONS

PRIVACY PRACTICES ACKNOWLEDGMENT

Our Commitment to your Privacy:

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

I have received the Notice of Privacy Practices
and have been provided an opportunity to review it.

Signature _____ Date _____

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**PRIVACY PRACTICES & DESIGNATED INDIVIDUALS
AUTHORIZATION FORM**

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____