HAGEN BEYER ENT CLINIC APMC

Patient Face Sheet

Patient Chart #:

Patient Name: _ ____ Todays Date: ______________

D.O.B ___________ Age:______ Sex: _____ Marital Status: ___________ Home Phone:______________

SSN: _________________ Driver's License #:_________________ Cell Phone: ______________

Mailing address: ____ Apt#: ____________________

City,State,Zip: ____

Patient's Employer Name:____

Address: ____ Phone:_______________

City,State,Zip: ____

Nearest Relative not living with you: ____

Home Phone: _________________ Cell Phone: _________________

If Child: Father's Name: ____ Phone:_______________

Place of Employment: ____

Mother's Name: ____ Phone:_______________

Place of Employment: ____

Guarantor Name: ____ D.O.B _______________

Mailing Address: ____ Phone:_______________

City,State,Zip: ____ SSN: _______________

If Spouse: Spouse's Name:____

Place of Employment:____ Phone:_______________

Primary Ins: ____ SSN: _______________

Insured 1 Name:____ D.O.B.: __________ Relation: __________

Secondary Ins: ____ SSN: _______________

Insured 2 Name:____ D.O.B.:__________ Relation:__________

Referring Physician Information:

Is Another Physician Referring you to see us? YES ___ NO ___ If YES, Please give Physician's Name:_______________________

*******FEES ARE DUE AND PAYABLE UPON COMPLETION OF THE OFFICE VISIT******

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFROMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR THE ABOVE INFORMATION.

____ ______________________

PATIENT/GUARDIAN OF MINOR DATE

******INSURANCE AUTHORIZATION AND ASSIGNMENT******

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER OF SERVICES FOR MYSELF AND/OR DEPENDENTS. I UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLES,CO-INSURANCE, OR AMOUNTS FOR SERVICES NOT COVERED BY THE INSURANCE CARRIER.

____ ______________________

PATIENT/GUARDIAN OF DATE