Puget Sound Ear, Nose & Throat / Proliance Surgeons, Inc., P.S.

Welcome To Our Office!

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ Birthdate: _____ Age: _____
Email Address: _____ May send information here? Yes No
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Work Phone: ( ) _____ Male: _____ Female: _____
Cell Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Work Phone: ( ) _____

* *

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Telephone: ( ) _____

* *

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

How did you learn about our practice? _____
Referred to this office by: _____
Primary Care Physician: _____

May we leave a message at your home? Yes No
May we contact you at work? Yes No

Over Please

Insurance Information

Patient's Name: _____ Today's Date: _____
First Middle Last

[Primary Insurance]
Name of Insurance Company:

_____

Address: _____
City: _____ State: _____ Zip: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company:

_____

Address: _____
City: _____ State: _____ Zip: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Group Number: _____ Policy ID Number: _____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? _____
Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts.

Your copay amount: $ _____

AUTHORIZATION FOR THE TREATMENT OF A MINOR:
I AUTHORIZE PROLIANCE SURGEONS INC. (Puget Sound Ear, Nose & Throat Center) TO TREAT THE MINOR PATIENT NAMED ABOVE

SIGNED _____

Signature of Patient or Responsible Party: _____

NOTICE OF PRIVACY PRACTICE:

We keep a record of the health care services we provide you. You may ask to see and copy the record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator. Our NOTICE OF PRIVACY PRACTICES describes in more detail how your health information may be used and disclosed, and how you can access your information.

Whom may we share your information with including financial account information?

Name:		Relationship:	
Name:		Relationship:	

RELEASE OF BENEFIT AND INFORMATION

i AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PROLIANCE SURGEONS, INC. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE, *INCLUDING MONTHLY SERVICE CHARGES ON PATIENT BALANCES OVER 30 DAYS.*
I AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM.
I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICE.

SIGNED _____ DATE _____