PEORIA EAR, NOSE AND THROAT GROUP, S.C.

7301 NORTH KNOXVILLE AVENUE
PEORIA, ILLINOIS 61614

Patient Information

Name______________________________ M.I. ____ D.O.B. __________ Male Female
Home Address______________________________ Age__________
City______________________________ State__________ Zip Code______________
Social Security Number______________________ Home Phone # ( )______________
Employer______________________________ Business Phone # ( )______________
Have you or any other family member been seen in this office before today? [ ] Yes [ ] No
If so, whom?______________________________ When?______________________

Parent/Guardian Information If Minor

Name of Mother/Guardian______________________________ D.O.B.______________
Home Address______________________________
City______________________________ State__________ Zip Code______________
Social Security Number______________________ Home Phone # ( )______________
Employer______________________________ Business Phone # ( )______________

Name of Father/Guardian______________________________ D.O.B______________
Home Address______________________________
City______________________________ State__________ Zip Code______________
Social Security Number______________________ Home Phone # ( )______________
Employer______________________________ Business Phone # ( )______________

Referring Physician Information

Name______________________________ Phone # ( )______________
Address______________________________ City______________
State__________ Zip Code______________

Billing Information

Who is responsible for the bill? (Parent)______________________________

Primary Insurance Carrier Information

Insurance Company Name______________________________
Address______________________________ City______________
State__________ Zip Code______________ Phone # ( )______________
Policy Holder's Name ______________________ Social Security Number______________
Group #/Policy/I.D.# ______________________ D.O.B. ______________

Secondary Insurance Carrier Information

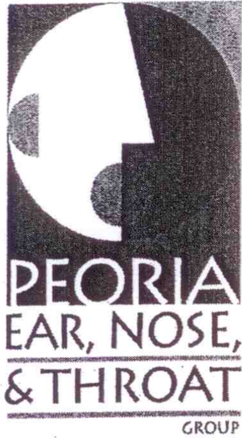
Insurance Company Name______________________________
Address______________________________ City______________
State__________ Zip Code______________ Phone # ( )______________
Policy Holder's Name ______________________ Social Security Number______________
Group #/Policy/I.D.# ______________________ D.O.B. ______________

I hereby request that all medical and/or surgical benefits including medical benefits to which I am entitled and government sponsored programs, private insurance and any other health plan be sent directly to: PEORIA EAR, NOSE AND THROAT GROUP, S.C.

This assignment will remain in effect until revoked by me in writing. 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. If collection is required, I understand and agree that I will be liable for all costs of collection, including but not limited to, attorney's fees and court costs. I hereby authorize said assignee to release all information necessary to secure payment.

PATIENT'S SIGNATURE
OR PARENT IF A MINOR ______________________________ DATE______________

Peoria Ear, Nose and Throat Group, SC
Notice of Privacy Practices



By signing below, I hereby acknowledge that I have received or have been offered a copy of Peoria Ear, Nose, and Throat Group's Notice of Privacy Practices effective April 14, 2003.

______________________________ ______________________
Print patient name Date

____
Signature of patient/representative

I hereby authorize this office to use or disclose my Patient health information to the following person(s):

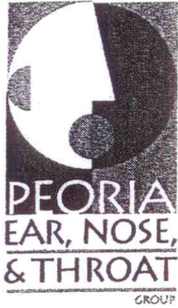
____

____

____

Do you give Peoria Ear, Nose, and Throat Group authorization to leave test results on your answering machine or voicemail?

Yes No



PATIENT PREFERENCE INSTRUCTIONS
PATHOLOGY, LABS, & TESTING

IN ACCORDANCE WITH MY CURRENT HEALTH INSURANCE PLAN, ANY LAB OR TESTING SHOULD GO THROUGH:

____

HOSPITAL NAME

ANY PATHOLOGY SHOULD BE SENT TO:

____

PATHOLOGY GROUP

____

PATIENT NAME

____ ________________

PATIENT OR GUARDIAN SIGNATURE **DATE**

____

PRACTICE INTAKE REP