PEDIATRIC PATIENT DEMOGRAPHIC SHEET

*****PLEASE COMPLETE ENTIRE FORM*****
*****WE ASK ALL PATIENTS TO SHOW THEIR INSURANCE OR MANAGED CARE MEMBERSHIP CARDS AND A PICTURE ID SO THAT WE MAY MAKE COPIES OF THEM*****

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

DOB: _____/_____/_____ Age: _____ SSN: _____-_____-_____ Gender: _____

Ethnicity: (circle) Hispanic or Latino Not Hispanic or Latino Declined to Specify

Race: (circle) Asian Black or African American Declined to Specify Native Hawaiian or Other Pacific Islander White

Preferred Language: (circle) English Spanish Declined to Specify

Mailing Address: _____
ADDRESS CITY STATE ZIP

Primary Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

How do you prefer to be contacted: (circle) call text email

Email Address: _____

Referring Physician: _____ Family Physician: _____

Pharmacy Preferred: _____ Address: (specific street and city) _____

GUARANTOR'S INFORMATION

Mother's First Name: _____ Last Name: _____

Address: _____
STREET ADDRESS CITY STATE ZIP

SSN: _____-_____-_____ ***(Social Security is Required)*** DOB: _____/_____/_____

Primary Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone:_____-_____-_____

Employer: _____ Is this your emergency contact? Yes or No

Father's First Name: _____ Last Name: _____
Address: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Primary Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Employer: _____

ENT has my permission to disclose my personal protected health and financial information to:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____
Secondary Insurance Carrier: _____

*****PAYMENT IS DUE FOR ALL OFFICE CHARGES ON THE DAY OF THE EXAMINATION*****

I hereby authorize, assign, and direct payment of basic and major medical benefits directly to ENT & Allergy Associates of South Georgia. I understand that I am responsible for any amount not covered by insurance, if my insurance has not paid any claim within 45 days, I will be responsible for any cost incurred by ENT & Allergy Associates for the recovery of this account. I also authorize the release of any information needed to determine benefits payable for related services. A photocopy of this authorization is as valid as an original.

Signature: _____ Date: _____

ENT & ALLERGY ASSOCIATES OF SOUTH GEORGIA
2910 N. Patterson Street
Valdosta, GA 31602

FINANCIAL POLICY

We are committed to providing you with the best possible patient care. Our goal is to keep your financial responsibilities as simple as possible.

Please initial on each line

____ If you have insurance we will file it as a courtesy to you. All co-payments, co-insurance and ***estimated*** patient portions for surgeries or in-office procedures will be due at "time of service".

____ Your insurance policy is an agreement between you, your employer and the insurance company. It is your responsibility to understand what services are covered, if you are in or out-of-network or if you have deductibles, etc. If payment is not received with 60 days from date of service, you will be expected to pay the balance in full.

____ Any outstanding account balances from previous appointments will be collected, before your appointment. For your convenience, we accept cash, checks, credit cards and Care Credit.

____ Non-payment may result in the rescheduling of your appointment.

____ Statements are mailed monthly for un-paid balances. It is the responsibility of the patient to monitor outstanding balances and pay accordingly. If there are any questions concerning any balance, please call our billing office.

____ It is your responsibility to provide us with your current address, primary contact phone number and insurance information at each visit. If you do not have proof of your current insurance at your visit, you will be considered a self-pay patient and payment will be due in full.

____ Balance's older than 60 days may be subject to collection fees up to 35% of balances due. Patient accounts submitted to a collection agency are also considered dismissed until all balances are paid in full.

____ All returned checks will be subject to an additional $35.00 collection fee.

Patient Name: _____

Patient Signature: _____

Responsible party: _____

Date: _____