PATIENT INFORMATION SHEET

924 Colonial Avenue, Building E • York, PA 17403 • (717) 843-9089 • www.yorkent.net

PATIENT INFORMATION

Name: _____ Date of Birth: _____ SS#: _____

Home Address: _____ Sex: ❑ Male ❑ Female

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employer: _____ Email Address: _____

Family Doctor: _____ Referring Doctor: _____

How did you hear about our practice? ❑ Family Doctor ❑ Friend/Relative ❑ Internet ❑ Yellow Pages ❑ Paper ❑ Email

Race: ❑ White ❑ Black/African-American ❑ Spanish ❑ American Indian ❑ Asian ❑ Hawaiian ❑ Other

SPOUSE OR EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

ADDITIONAL INSURANCE INFO (if information required below is not found on card)

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's SS#: _____ Employer: _____

IF PATIENT IS UNDER 18 (fill in completely)

Father's Name: _____ Date of Birth: _____

Address (if different): _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employer: _____

Mother's Name: _____ Date of Birth: _____

Address (if different): _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Employer: _____

MEDICAL RECORD & INSURANCE AUTHORIZATION: I certify that the above information is correct to the best of my knowledge. I have received a copy of the Financial Policy of York ENT Associates and understand my financial responsibility for services. It is our office policy and state law to maintain medical records for a period of seven years from the date of your last medical visit. The medical record for any patient under 18 years of age shall be retained until two years after their 18th birthday, if they have not been seen in over seven years. At that time you may request your records for personal use as we no longer will store them in our facility. Any records not requested at that time will be destroyed. I authorize the release of any information necessary to determine benefits for services rendered by York ENT Associates. I request payment of authorized benefits be made on my behalf to York ENT Associates for any services furnished to me by their physicians or suppliers.

Signature: _____ **Date:** _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to York ENT Associates for any services furnished to me by the provider of services. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Medicare Beneficiary Signature: _____ **Date:** _____