EASTERN VIRGINIA
EAR, NOSE & THROAT
SPECIALISTS

PATIENT INFORMATION

PATIENT # _____

LAST NAME	FIRST NAME	M.I.	SEX ○M ○F	DATE OF BIRTH / /
ADDRESS	APT/STE #		MARITAL STATUS ○S ○M ○D ○W	
CITY	STATE	ZIP CODE	EMAIL	
HOME PHONE PREF ○	CELL PHONE PREF ○		WORK PHONE PREF ○	
EMPLOYER	OCCUPATION		PREFERRED LANGUAGE ○DECLINE	

RACE ○NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ○WHITE/CAUCASIAN
○AMERICAN INDIAN OR ALASKA NATIVE ○OTHER_____
○BLACK OR AFRICAN AMERICAN ○ASIAN ○DECLINE

ETHNICITY ○NOT HISPANIC OR LATINO ○HISPANIC OR LATINO ○DECLINE

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE

RESPONSIBLE PARTY / GUARANTOR

○ SELF – BY CHECKING HERE I CERTIFY THAT I, THE PATIENT, AM THE RESPONSIBLE PARTY AS I AM OVER 18 YEARS OF AGE

GUARANTOR LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH / /	SOCIAL SECURITY NO. - -
ADDRESS			CITY	STATE / ZIP CODE
HOME PHONE	CELL PHONE		WORK PHONE	
RELATIONSHIP TO PATIENT	EMPLOYER		OCCUPATION	

PRIVACY / HIPAA ACKNOWLEDGEMENTS

HIPAA Acknowledgements: All patients must check all that apply

_____ Initial to approve

○ I acknowledge that I have been provided with a copy of the Eastern VA ENT Specialists Notice of Privacy Policy
○ NO messages should be left on any voicemail or with anyone other than the patient
○ Is it ok to leave a message regarding your health information at your : ○Home ○Cell
○ By default, no other persons may have access to my medical record except the following people:

NAME/RELATIONSHIP	NAME/RELATIONSHIP

INSURANCE INFORMATION

FOR YOUR CONVENIENCE, WE WILL ASSIST YOU WITH THE INFORMATION NECESSARY TO FILE YOUR INSURANCE. PLEASE ALLOW US TO COPY YOUR INSURANCE CARDS.

PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY	
ID NO.	GROUP NO.	ID NO.	GROUP NO.
SUBSCRIBER'S NAME	DATE OF BIRTH / /	SUBSCRIBER'S NAME	DATE OF BIRTH / /
RELATION TO PATIENT	SS# - -	RELATION TO PATIENT	SS# - -

DEEMED CONSENT – CONSENT FOR TREATMENT – RELEASE OF MEDICAL INFORMATION – ELECTRONIC COMMUNICATIONS – NO GUARANTEE

- Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infection of HIV or hepatitis B or C viruses, and have results released to the exposed employee.
- I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as any testing and/or treatment carried out by Eastern Virginia Ear, Nose & Throat Specialists.
- I agree that Eastern Virginia Ear, Nose & Throat Specialists may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.
- We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not share your information and you may opt out at any time.
- Chaperones may be present during examinations. Any request for a chaperone made by a patient and/or family member will be honored. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment. If patient is under 18 years of age a legal guardian must be present for appointments.

FINANCIAL AGREEMENT – INSURANCE AGREEMENT

- I hereby authorize treatment to patient by any Eastern Virginia Ear, Nose & Throat Specialists provider and/or affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does not constitute covered services, including denied Worker's Compensation claims, as well as attorney fees of 33 1/3% and other related costs of collection should such action become necessary.
- I understand that I have the right to choose to have or not have all recommended testing by the provider, but if the testing is performed, I am fully responsible for any charges left to my responsibility after insurance has processed the claim.

SIGNATURE OF PATIENT/GUARANTOR	RELATIONSHIP TO PATIENT	DATE