Oregon Ear, Nose and Throat, PC

James J. Knackstedt, MD

Patient Information

Patient Name:_____Social Security #:_____
Last First MI

Date of Birth:_____ Sex: M or F Marital Status: Single Married Other

Street Address:_____
Street City State Zip

Mailing Address:_____
Street City State Zip

Home Phone:_____Cell Phone:_____Work Phone:_____

Employer / School:_____ Retired: Y or N

Primary Care Physician:_____Who Referred the Patient?_____

Who can we contact in an emergency?_____/_____Phone:_____
(Name / Relationship to Patient)

Responsible Party Information:

Responsible Party:_____Date of Birth:_____Social Security #:_____

Street Address:_____Mailing:_____
Street City State Zip

Employer:_____Phone:_____

Spouse:_____Date of Birth:_____Social Security #:_____

Employer:_____Phone:_____

Billing Information

Is this visit because of an accident? Y or N If so, what type? Auto – Work – Other Date of Injury:_____

Primary Insurance:_____Subscriber Name:_____Date of Birth:_____
(Whose Policy is this?)

ID#:_____Employer Name & Group #:_____

Ins. Address:_____Phone:_____

Secondary Insurance:_____Subscriber Name:_____Date of Birth:_____
(Whose Policy is this?)

ID#:_____Employer Name & Group #:_____

Ins. Address:_____Phone:_____

Patient Responsibility and Consent:

I understand that it is my responsibility to notify this office of any change in my address or insurance. I assign the medical benefits paid by my insurance carrier(s) to Oregon Ear, Nose and Throat, P.C. I understand that I am financially responsible to Oregon Ear, Nose and Throat, P.C., for charges not covered by my insurance. I agree to pay all collection costs and reasonable attorney fees if I fail to promptly pay this account when due. I understand that a finance charge or late fee may be applied to my account, not to exceed what is allowed by law, if I fail to promptly pay this account when due. By signing this form, I am granting consent to request, use and disclose my protected health information including prescriptions for the purposes of continuity of medical care, payment of my bill, and health care operations.

_____
Patient and / or Responsible Party Signature Email Address Date