Sumter Ear, Nose, Throat & Facial Plastic Surgery, LLC

LAST NAME: **FIRST NAME:** **MI**
II/III/IV/Jr/Sr_____ _____ _____

Social Security # (Required for children also) **Date of Birth:** **Sex: M or F**

_____-_____-_____ _____/_____/_____ **Family Doctor**_____

Address: **City:** **State:**
_____ _____ **ZIP:**_____

Home Phone: **Cell Phone:** **Work Phone:**
(_____)_____ **(_____)**_____ **(_____)**_____

CONTACT PREFERENCE: □ HOME □ CELL □ WORK □ OTHER (____) _____ -_____

Marital Status: **□Single □Married □Widowed □Other** **Language:** **□ English □ Spanish □ Other**_____

Race: **□African American □Asian □Hispanic □Other Pacific Islander □White □Other Race □Do not wish to report**

Emergency Contact: **Emergency Contact Phone:** **Relationship**

_____ **(_____)**_____-_____ _____

_____ (_____)_____-_____ _____

Patient Portal/Email Consent: This will give us permission to contact you by computer or on your cell phone.

□ **YES,** I hereby authorize Sumter ENT to use the email address I have provided as a means to communicate test results and other information to me through the patient portal.

E-mail:_____

□ **NO,** I do NOT wish to communicate through the patient portal and would prefer to be reached by phone for any communications.

- □ **I do not have email address**
- □ **I do not wish to disclose email address**

X_____ _____
*** Signature of Patient or Legal Representative** **Date**

Authorization for Prescription History: I consent to allow the physicians of Sumter ENT and appropriate staff to access my prescriptions from external sources. (This would allow us to obtain your prescriptions from a pharmacy, the hospital, your primary care doctor, etc.)

□ **Yes,** I give permission for the physicians of Sumter ENT and the appropriate staff to have access to my prescriptions from external sources.

Name of Your Pharmacy:_____

Name of Secondary Pharmacy:_____
(For patients who use Shaw AFB pharmacy, we need a secondary pharmacy)

□ **No,** I do not wish to give permission for anyone to have access to any of my prescriptions from any external sources. (Checking this box will NOT allow us to prescribe any medication for you)

X_____ _____
***Signature of patient or legal guardian** **Date**

Sumter Ear, Nose, Throat & Facial Plastic Surgery
David Lovice, MD Paul A. Evangelisti, MD

Insurance Information

PATIENT NAME: _____ _____ _____
Last First MI

Please list below the names of each insurance company that we will file claims to for this medical treatment. **DO NOT LIST LIFE INSURANCE POLICIES OR DISABILITY POLICIES.** Please give us your insurance identification cards so that we can make copies to be placed in your medical record.

Primary Insurance Company

Name of Primary Insurance Company	Employer
Name of Policyholder	Birth Date
ID#	Social Security Number of Policy Holder
Relationship of Patient to Policyholder ( ) Self ( ) Spouse ( ) Child	

Secondary Insurance Company

Name of Primary Insurance Company	Employer
Name of Policyholder	Birth Date
ID#	Social Security Number of Policy Holder
Relationship of Patient to Policyholder ( ) Self ( ) Spouse ( ) Child	
If student insurance, please list name and address of school: Name of School _____ Address of School _____	

If Worker's Compensation **(TO BE COMPLETED BY OFFICE ONLY)**

Employer's Name	Insurance Company
Employer's Address	
Employer's Phone	
Person's Name Authorizing Treatment	Employer of Insurance Company

FILING INSURANCE CLAIMS IS A SERVICE PROVIDED WITHOUT CHARGE AND IN NO WAY RELIEVES YOU OF YOUR RESPONSIBILITY FOR YOUR BILL

See other side

BENEFITS RELEASE

I authorize payment of medical benefits to Sumter Ear, Nose Throat & FPS, LLC as indicated by the assignment on any and all claims filed. I also request payment of government benefits to the party who accepts assignment.

MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to process any and all claims filed.

FINANCIAL RESPONSIBILITY RELEASE

I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident for which I am not at fault. I understand that any copayment/ deductibles or other insurance contract provisions are my responsibility and that failure to adhere to my insurance policy will result in my personal responsibility for all charges incurred.

_____ _____

Patient or Responsible Party Signature Date

Payment is required at the time of service for all charges unless prior arrangements have been made. (Excluding those patients whose primary insurance is Medicare/Medicaid, a PPO/HMO or Worker's Compensation with which we participate – payment of co-pays and deductibles are expected.) As a courtesy to our patients, however, we will file for each date of service. Please present your insurance card(s) to the receptionist.

METHOD OF PAYMENT: ( ) Cash ( ) Check ( ) Visa/MC

Sumter Ear, Nose, Throat & Facial Plastic Surgery, LLC

Patient Consent Form

Patient Name: _____

Date of Birth: _____

Patient Portal/Email Consent

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E-mail:_____

□ **NO,** I do NOT wish to communicate through the patient portal and would prefer to be reached by phone for any future communication(s).

- □ **I do not have email address**
- □ **I do not wish to disclose email address**

X_____ _____

*** Signature of Patient or Legal Representative** **Date**

**** See other side ****

Authorization for Prescription History

I consent to allow the physicians of Sumter ENT and appropriate staff to access my prescriptions from external sources. (This would allow us to obtain your prescription information from a pharmacy, the hospital, your primary care doctor, etc. and allow us to send prescriptions to your pharmacy)

□ **Yes,** I give permission for the physicians of Sumter ENT and the appropriate staff to have access to my prescriptions from external sources.

Name of Your Pharmacy:_____

Name of Secondary Pharmacy:_____

(For patients who use Shaw AFB pharmacy, we need a secondary pharmacy)

□ **No,** I do not wish to give permission for anyone to have access to any of my prior prescription history from any external sources. (Checking this box will NOT allow us to prescribe any medication for you)

X_____ _____

***Signature of patient or legal guardian** **Date**

Patient Name DOB Today's Date

PLEASE LIST CURRENT MEDS

*****Including over the counter medication*****

Name of Medication	Dosage	How often taken

List meds you have taken for the problem for which you are referred to us.