EAR, NOSE, AND THROAT MEDICAL GROUP OF WASHINGTON, P.C.

6845 ELM STREET, SUITE 215
McLEAN, VA 22101
703-356-5601

2021 K STREET, N.W. SUITE 810
WASHINGTON, DC 20006
(202) 223-3560

PATIENT REGISTRATION – *Please Print Clearly*

Patient Name: (First, M.I., Last)_____

Date of Birth: _____ Age: _____ Sex: Male/Female

Home Address (Street):_____

(City, State, Zip) _____

Social Security #: _____ Email: _____

Home phone #: _____ Cell phone: _____

Occupation:_____ Work Phone:_____

Employer and address: _____

Spouse/Parent/Other Name: _____

Address: _____ Work Phone: _____

Emergency Contact: _____ Phone:_____

Referring Physician / Person (please circle): _____

Referring M.D.'s address: _____ Phone: _____

Pharmacy Name:_____ Pharmacy Phone: _____

Pharmacy Address (list of pharmacies available at front desk):_____

INSURANCE/GUARANTOR INFORMATION

Insurance subscriber name:_____ Subscriber's DOB: _____

Relationship (if not patient):_____ Social Security No.: _____

Insurance Company:_____ Group ID No.: _____

Subscriber employer: _____ Subscriber No.:_____

Policy concerning payment of medical bills:

Our policy requires full payment to be made at the time services are rendered unless we participate with your insurance company, in which case any co-payment is due. Whether or not your insurance company pays in full, a portion, or no portion is a matter between you and your insurance carrier. If you are using out-of-network benefits please understand you may be subject to a higher co-payment or deductible or even the entire bill. Some hearing tests, lab work and cultures may not be covered under the co-pay portion of your insurance coverage. Depending on culture results - sensitivity testing may be necessary at an additional charge. Unless other arrangements have been made, any unpaid balances are due within 30 days of billing.If for any reason your account is turned over to a collection agency you will be liable for any additional expenses incurred by such action. There is a $35.00 fee for all returned checks and for any missed appointments not cancelled within 24 hours.

Health Information Privacy Practices:

This practice is dedicated to maintaining the privacy of your health information. Certain special circumstances may require us to use or disclose your health information as described in our Notice of Privacy Practices. A copy of this policy is available for you and is also posted in the office.

Patient Authorization:

I certify that the above information is correct and further authorize the release of my medical information for this or any other related claim to my insurance company. I request payment to be sent to the above named provider. I also hereby acknowledge that I have been presented with a copy of Ear, Nose & Throat Medical Group of Washington, P.C.'s Notice of Privacy Practice.

_____ _____

Date: Signature of Patient (or Guardian)v

Personal Medication Form

Name: _____ **DOB:** __/__/__ **Date form last updated:** __/__/__

Your complete medication history is important to your physicians and to the hospital. Please fill out the following form to keep us informed of your current medications.

Allergies: Are you allergic to medications, iodine, food, tape, or latex? List each medication you are allergic to and the reaction you experienced.

Allergy	Reaction

Medications: Please list all prescription and non-prescription medications, herbals, eye drops, nutritional supplements, inhalers, etc. that you use.

Name of Medication	Dose	Frequency

Please continue on back if necessary. Thank you!